Massachusetts Division of Health Care Finance and Policy

An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents

Chapter 2: MassHealth

A Report to the Senate Committee on Ways and Means,
House Committee on Ways and Means
and Joint Committee on Health Care

September 2000

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I. Executive Summary

Section 17 of Chapter 47 of the Acts of 1997 required the Massachusetts Division of Health Care Finance and Policy to file two reports evaluating MassHealth, the Children's Medical Security Plan, the Senior Pharmacy Assistance Program and the Uncompensated Care Pool. The first report, An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents, was completed on March 2, 1998. That report, encompassing information on all four programs, was based on qualitative methods and focused on processes of care. The follow up reports are being released in a series of publications with more detailed information on each individual program. These publications will include information related to ongoing operations, the characteristics of the uninsured and insured, changes in the source of insurance coverage, and the interactions of the programs and the impact on participants. This report is the second in the series and is concentrated on evaluating the MassHealth program.

Key findings from this report are as follows:

- Massachusetts' uninsured rates for ages 0 to 65 have dropped from 14.3% to 11.6% compared to the national rates which have increased from 18.2% to 18.4% (between 1997 and 1998).

- Massachusetts' health care coverage rates by Medicaid for ages 0 to 65 is 31.7% higher than the national rate: 13.7% compared to 10.4%.

- MassHealth enrollment has been very successful with a 41% member increase between the onset of reform in 1997 and June 30, 2000.

- The churning of enrollment caused by required redetermination activity is having an impact on service providers.

- Nearly all MassHealth providers are facing increasing financial pressures due in part to rising costs, the effect of the federal Balance Budget Act, and negotiated contracts with managed care providers.

- Although aggregate health care utilization at acute care hospitals has increased, the increase is not as much as might be expected given the large rise in the number of MassHealth member enrollees.

- Awareness and sensitivity to cultural differences between members and their providers is key to member satisfaction.

- Quality ratings in terms of HEDIS 1999 results generally show that MassHealth managed care plans compared favorably to regional and state commercial managed care organization plans, as well as to the applicable *Healthy People 2000* goals.

- Questions among providers remain regarding long term State and Federal support of the MassHealth expansions.

Recommendations for next steps focus on how to build upon the results of health reform; the analysis presented here suggests that future efforts should focus on three main issues:

- Stability in the eligible population;
- Provider reimbursement; and
- Maintaining the gains made through health reform.

II. Introduction

Mandate
Section 17 of Chapter 47 of the Acts of 1997, An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth, charges the Massachusetts Division of Health Care Finance and Policy with evaluating four Massachusetts programs:

- MassHealth
- The Children's Medical Security Plan
- The Senior Pharmacy Assistance Program
- The Uncompensated Care Pool

The Division is required to file a report of these evaluations with the Massachusetts House and Senate Committees on Ways and Means, and the Committee on Health Care. This report focuses on the MassHealth program.

Focus of report
This report looks at issues related to the implementation, expansion and operation of the MassHealth program, including the impact on insurance trends. The evaluation was conducted using aggregate data gathered from the Massachusetts Division of Medical Assistance (DMA), as well as semi-structured interviews conducted with a number of key stakeholders. This report examines trends in enrollment, program expenditures and financing, some aggregate utilization trends, quality and satisfaction, as well as other issues raised concerning MassHealth and the implementation of health reform.

Data Sources
Many sources of information and data were investigated and utilized in preparing this report. Data analyzed include enrollment statistics, expenditure and budget data and data from other management reports. CPS data are used to review long-term trend data regarding the uninsured, Medicaid and the working insured population. Much has been written and discussed regarding the validity of the CPS data, and there have been specific issues around measurement particularly with respect to the uninsured population. However, the CPS data are still the best available source for trend data, and for comparative national data. Enrollment data are from the DMA Caseload Snapshot Report. The Snapshot Report is produced monthly and counts the number of MassHealth enrollees at a specific point in time. Expenditure data are obtained from the DMA Budget Office's Forecast Summary Report. The utilization section is based on data submitted to the Division of Health Care Finance and

Policy by Massachusetts acute care hospitals. There were many DMA reports reviewed, as well as results from a number of interviews with key stakeholders.

Legislation
In April 1995 the U.S. Department of Health and Human Services approved Massachusetts' request for a five year Medicaid research and demonstration waiver in accordance with section 1115 of the Social Security Act. Under this waiver, the implementation of the MassHealth expansion programs is occurring as a five year "demonstration project", which may be renewed, subject to federal approval. The state legislature then passed Chapter 203 of the Acts and Resolves of 1996, "An Act Providing Improved Access to Health Care" enabling DMA to begin expanding MassHealth eligibility on July 1, 1997. The demonstration project began on July 1, 1997 and continues through to June 30, 2002. During the first year of the waiver, DMA expanded MassHealth eligibility to include children, their parents, disabled adults, and long term unemployed adults with family income at or below 133% of the federal poverty level (FPL).

Chapter 47 of the Acts and Resolves of 1997, "An Act to Assist in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth" passed in July 1997. This legislation enabled the implementation of the Insurance Partnership (IP, originally known as the Insurance Reimbursement Program) and authorized premium assistance to eligible families and employer incentive payments to eligible small employers. In August 1997 the federal government enacted Title XXI of the Social Security Act, allowing states to expand coverage to certain low-income children through the Children's Health Insurance Program (CHIP). The state legislature then enacted Chapter 170 of the Acts of 1997, in November 1997. This legislation enabled the expansion of MassHealth eligibility up to 200% of the FPL for children, pregnant women, and newborns. During the second year of the waiver, ending June 30, 1999, implementing premium assistance and expansion to 200% of the FPL have been the major focus of activity at DMA. Specifically, starting in August 1998, DMA expanded coverage to a number of new groups:

- Children's eligibility was extended through age 18;
- MassHealth Standard eligibility was expanded to children in households with income from 134% of the FPL up to 150% of the FPL;
- MassHealth Standard eligibility was expanded to newborns and pregnant women in households with income from 185% of the FPL up to 200% of the FPL;
- Family Assistance was implemented, expanding eligibility to children with family income between 150% and 200% of the FPL, and qualified adults with income at or below 200% of the FPL; and
- The Insurance Partnership was implemented.

III. Program Description

MassHealth offers comprehensive health care coverage under the federal 1115 waiver to more than 780,000 eligible Massachusetts residents, including low-income families, children through age 18, pregnant women, individuals with disabilities, and individuals out of work for an extended period of time. Including the senior population MassHealth offers coverage to more than 900,000 members in total.

MassHealth provides health care benefits to eligible members through seven coverage types: MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, MassHealth Basic, MassHealth Buy-In, MassHealth Prenatal and MassHealth Limited. Two of these coverage types are new under health reform: Family Assistance and Basic. In addition, MassHealth Standard and Limited have seen a significant increase during the health reform period. This report will focus on the coverage types most significantly affected by health reform.

The federal government considers the Massachusetts Medicaid population under the age of 65 as the primary "waiver" population. Thus, for the purposes of this report, we are calling all Medicaid members, except seniors and other small specialty populations, the health reform population.

The majority of MassHealth recipients receive health care benefits under the MassHealth Standard benefit package. On June 30, 2000, nearly 85%, or 670,138 of health reform members received coverage under MassHealth Standard. MassHealth Standard offers a rich benefit package and most members are enrolled in managed care. It covers inpatient and outpatient hospital services; medical services including laboratory, x-rays, pharmacy and medical equipment; inpatient and outpatient mental health and substance abuse services; well-child screenings; transportation services; and for disabled adults who also get Medicare Part B- payment of the Medicare premium, coinsurance, and deductibles. MassHealth Standard enrollment has grown about 21% since the onset of health reform expansion.

MassHealth Basic offers coverage to those who are under the age of 65 and have not worked in over a year, are not eligible for unemployment benefits and do not have health insurance. Family income can be no more than 133% of the FPL. Most of the same services are covered as under MassHealth Standard except for non-acute services such as adult day health and adult foster care, hospice, nursing facility services or transportation services (except for emergency ambulance). On June 30, 2000, 7.8% of MassHealth members received coverage under MassHealth Basic. This population has experienced significant growth under health care reform, more than had been expected.

MassHealth CommonHealth offers health care benefits similar to MassHealth Standard to disabled adults and children who are not eligible for MassHealth Standard. There is no income limit but recipients with income above a certain amount may have to pay a premium or meet a one-time deductible. While CommonHealth accounted for just 9,516 (1.2%) of health reform members on June 30, 2000, it has grown nearly 159.6% since the onset of the health reform expansions.

MassHealth Family Assistance offers coverage to children and some working adults who are not eligible for MassHealth Standard or CommonHealth. There are two types of Family Assistance, Direct Coverage and Premium Assistance. Family Assistance pays part of a family's health insurance premium if the family has or can get qualified health insurance from their employer. If the family does not have or cannot obtain private health insurance, children under age 19 will be enrolled in a managed care health plan through MassHealth. Family Assistance will pay part of an employer-sponsored health insurance premium in the following cases: eligible applicants without children, if they work for a qualified employer[i], or for the self-employed meeting DMA qualified employer rules. Family Assistance also offers immediate coverage for uninsured children for a limited amount of time pending receipt of required information. On June 30, 2000 total Family Assistance members accounted for 3.7% of total health care reform members. About 57% of Family Assistance recipients are children enrolled in a health plan directly through MassHealth.

MassHealth Limited provides emergency health service coverage to recipients who, under federal law, have an immigration status that prevents them from being eligible for other MassHealth services. Undocumented immigrants who apply only for MassHealth Limited are not required to report a social security number and DMA will not match their names with any other agencies including the Immigration and Naturalization Service. Covered services comprise inpatient and outpatient hospital emergency services (including labor and delivery), certain services provided by doctors and clinics outside the hospital, pharmacy used to treat an emergency condition, and ambulance transportation. On June 30, 2000, MassHealth Limited recipients accounted for more than 2% of the total health care reform population.

MassHealth Prenatal offers health care services immediately to pregnant women for up to 60 days. During this "presumptive eligibility" period, DMA will determine if the recipient is eligible for another MassHealth benefit package. All routine prenatal office visits and tests are covered, but labor and delivery services are not. There were 270 members on June 30, 2000, and this coverage type will not be discussed further in this report.

IV. **Enrollment, Expenditure and Utilization**

Enrollment

DMA focused much effort on streamlining eligibility requirements and expanding outreach activities. As a result of these activities many new enrollees were reached that would have been eligible under pre-waiver eligibility rules. The enrollment information provided here is for all of the "waiver" population.

MassHealth members grew from 557,372 on June 30, 1997 to 788,649 members on June 30, 2000. This is a very impressive growth rate in enrollment of more than 41%. The most rapid growth occurred during the first year of health reform with the health reform population growing by nearly 28% by the end of June 1998, and growing another 9% during the second year of health reform. It is interesting to note that on June 30, 1997 adults comprised approximately 55% of the total health reform population and grew by more than 57% by June 30, 2000. Children, at 45% of the population at the beginning of the health reform, grew

by about 28%, and on June 30, 2000 comprise just over 50% of the health reform population (see Figures 1 and 2).

MassHealth Standard Enrollment
MassHealth recipients in MassHealth Standard have grown from 553,706 members on June 30, 1997 to 670,138 on June 30, 2000, an increase of 21%. Non-disabled children have grown by 19.5% and account for more than 51% of the total on June 30, 2000. Non-disabled adults have grown by 31% while the total MassHealth Standard disabled population has increased by 15.3%. Non-disabled adults and the total disabled each account for just over 24% of the total MassHealth Standard enrolled on June 30, 2000. (see Figures 3 and 4)

MassHealth Basic Enrollment
MassHealth Basic is designed to provide access to health insurance coverage for the long-term unemployed with family income no more than 133% of the FPL. The recipients in Basic are mostly adults. MassHealth Basic enrollees have many characteristics in common with the population that typically has received health care services reimbursed through the Massachusetts Uncompensated Care Pool[ii]. At the end of its first year, fiscal year 1998 (FY 1998), Basic had 43,135 enrollees. The second year brought a 37% increase in enrollment for a total of 59,127 enrollees on June 30, 1999. It is interesting to note that DMA projection curves for the Basic enrollment were close to the actual curve, just fewer in number than actual enrollment. DMA projected that enrollment would begin holding steady around September 1998 at around 40,000 enrollees. In fact the growth rate has slowed in the last three-quarters with an enrolled population staying around 60,000. (see Figure 5)

MassHealth Limited Enrollment
Enrollment in the first year for MassHealth Limited was 5,005 enrollees. The second year saw significant growth with the number of enrollees more than doubling. In the third year enrollment has continued to grow another 69%, for a total of 18,313 enrollees on June 30, 2000. Adults make up 66% with children accounting for 33% of the Limited population. (see Figure 6)

MassHealth CommonHealth Enrollment
On June 30, 1997, MassHealth CommonHealth had 3,666 recipients. In the first year enrollment increased by 16%. In the second year enrollment grew by more than 80% and in the third year enrollment has increased another 23.4% to 9,516 recipients on June 30, 2000. This is an extraordinary growth rate, fueled primarily by the non-working disabled adult population, of more than 159% during the health reform period. (see Figure 7)

MassHealth Family Assistance and the Insurance Partnership Enrollment
MassHealth Family Assistance and the Insurance Partnership implementation is occurring in three phases. The first two phases occurred during the second year of the waiver. Phase I was implemented beginning in the summer of 1998. This phase enrolled eligible uninsured children receiving direct coverage while insured children or those with access to employer sponsored family health insurance received premium assistance. Much of the activity during this phase focussed on moving eligible children from the Children's Medical Security Plan, a

Figure 1 This figure shows the trend in total MassHealth enrollment.

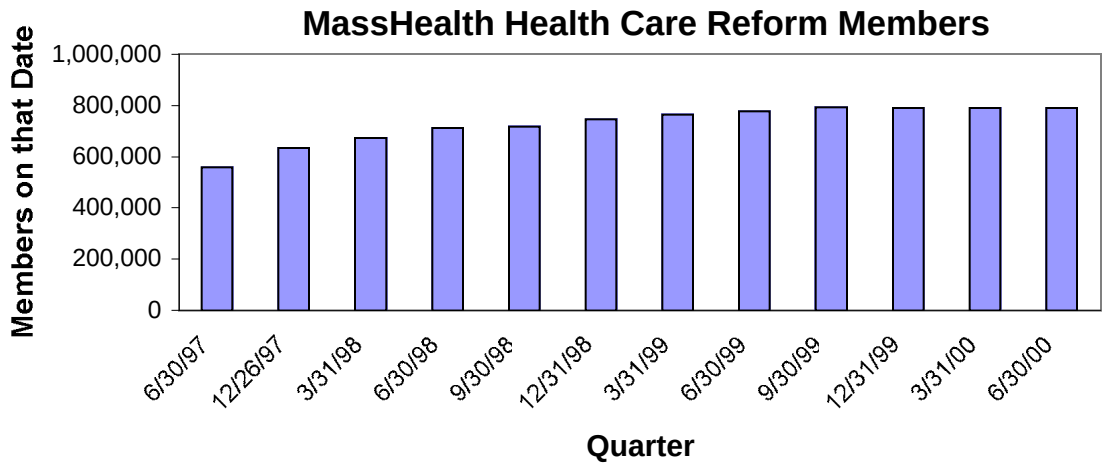
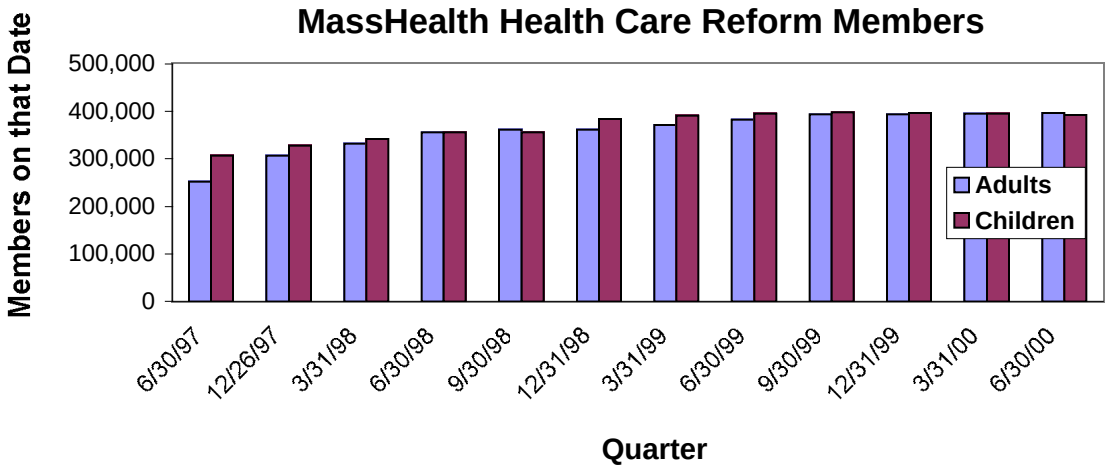


Figure 2 This figure shows the trend in MassHealth enrollment by adults and children.



Data source: DMA Snapshot Report, missing one quarter of data for 9/30/97

Figure 3 This figure shows the trend in MassHealth standard enrollment.

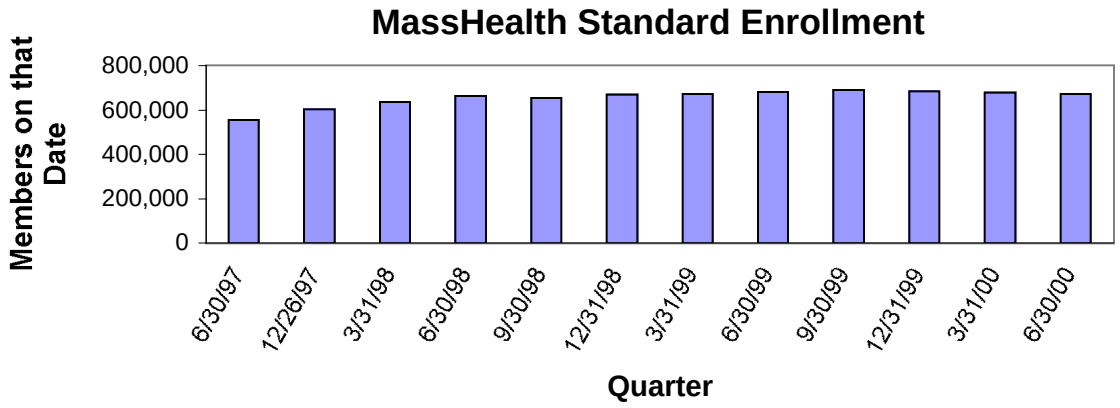
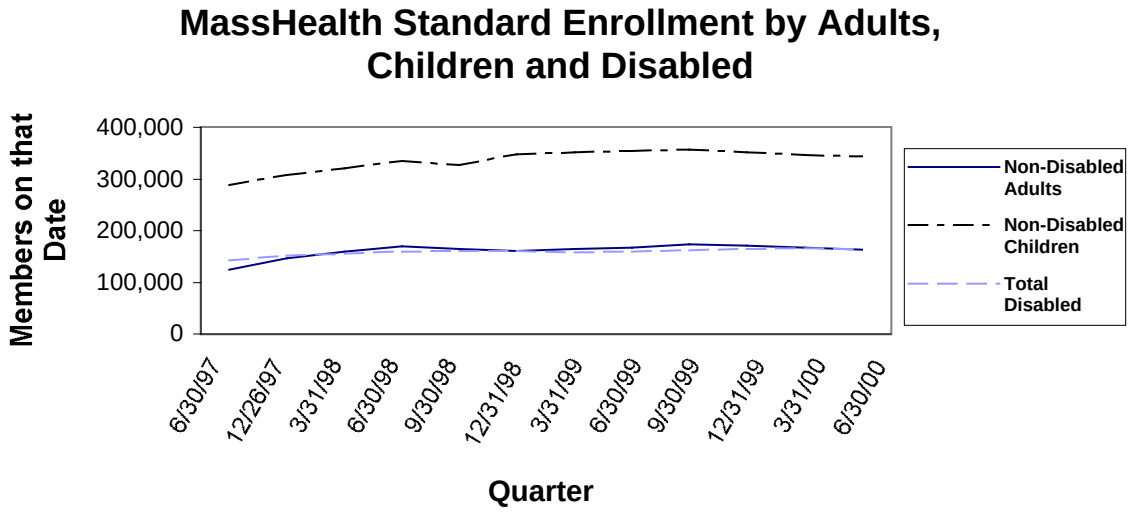


Figure 4 This figure shows the trend in MassHealth standard enrollment by adults, children and disabled.



Data source: DMA Snapshot Report, missing one quarter of data for 9/30/97

Figure 5 This figure shows the trend in MassHealth basic enrollment.

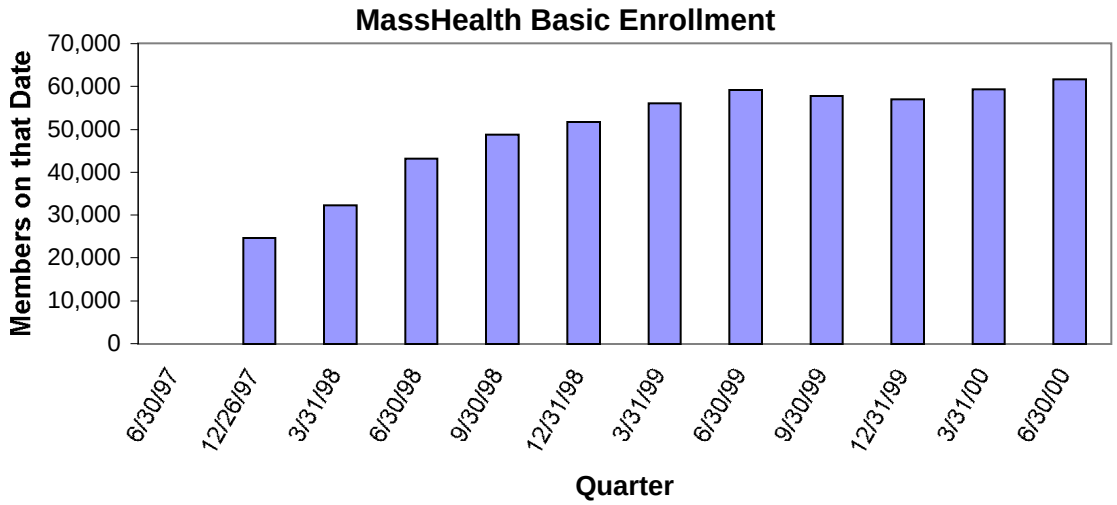
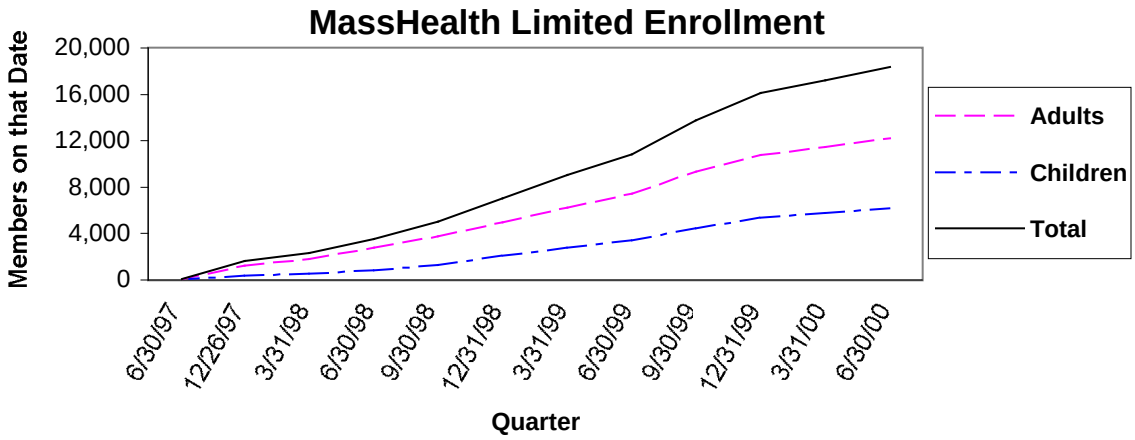


Figure 6 This figure shows the trend in MassHealth limited enrollment.



Data source: DMA Snapshot Report, missing one quarter of data for 9/30/97

Figure 7 This figure shows the trend in MassHealth CommonHealth enrollment.

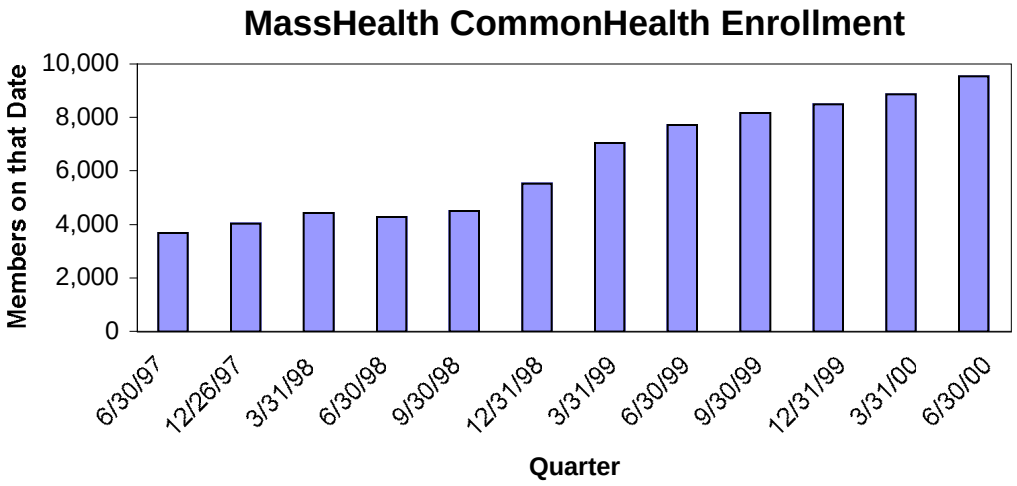
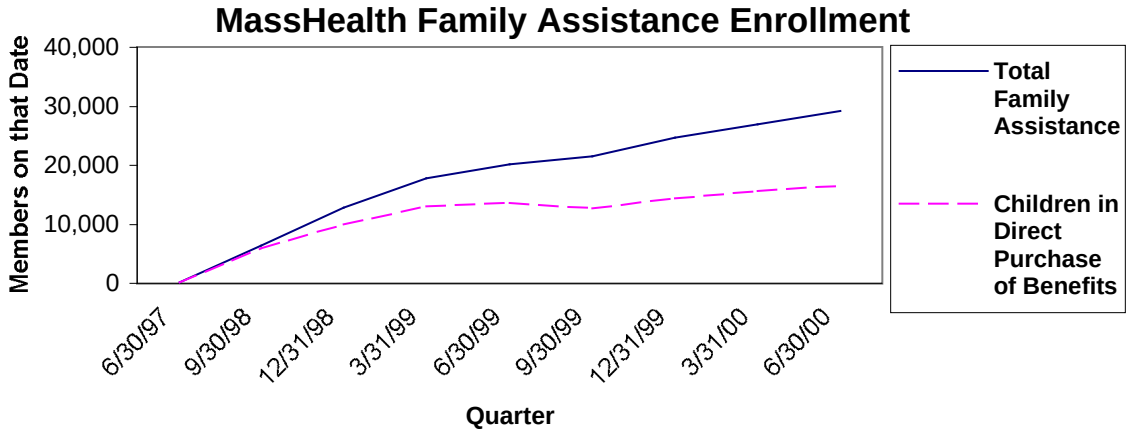


Figure 8 This figure shows the trend in MassHealth family assistance enrollment.



Data source: DMA Snapshot Report, missing one quarter of data for 9/30/97

state-sponsored primary and preventive health coverage program operated by the Department of Public Health, into MassHealth.[iii] This part of the implementation was quite successful. On September 30, 1998 there were 5,846 children enrolled under direct coverage, comprising nearly 92% of total Family Assistance enrollment. On September 30, 1999, enrollment of children under direct coverage increased by 117%, and on June 30, 2000 this had increased again by another 30% to 16,502 children, accounting for 56.7% of the total Family Assistance enrollment of 29,102. (see Figure 8)

Phase 2 introduced the Insurance Partnership which was implemented beginning in February 1999. In Phase 2, adults working for qualified small employers purchasing health insurance through a Billing and Enrollment Intermediary (BEI) became eligible for premium assistance. Phase II activity was concentrated on administrative and operational issues. Enrollment activity during the first year of the Insurance Partnership was somewhat limited. By the end of June 1999, 160 small employers participated, comprised primarily of the self-employed at 67%. These 160 employers accounted for 1,072 policies receiving premium assistance, for an estimated 3,517 covered lives. As of July 20, 2000, 1,439 small employers are participating of which 970 are self-employed. These 1,439 employers account for 1,752 policies for an estimated 4,043 covered lives.

Phase 3 implementation began in January 2000.This phase expands coverage to adults whose employers do not purchase insurance through a BEI. DMA has also increased promotion and marketing activities. It is too early to see what results these most recent activities will have, and progress will continue to be monitored.[iv]

Expenditures[v]: All Enrolled Members
The DMA Budget Office produces a quarterly date of service expenditure estimate and forecast. Expenditure data presented here consist of actual expenditures for FY 1995 through FY 1997, estimated expenditures for FY 1998 and FY 1999, and projected data for fiscal year 2000. Trend information is available with actual expenditures for years prior to the health reform activity. Expenditure information is also broken out between the disabled and non-disabled population.

Total expenditures for all MassHealth health reform enrollees is projected to grow from more than $3.2 billion in FY 1995 to more than $4.3 billion in FY 2000. DMA estimates the largest percentage growth has already occurred between FY 1997 and 1998 with an increase of 9.3%. Over the health reform period from1997 to 2000 total expenditures are projected to grow by 28.7%. (see Figure 9) The most significant cost increase can be seen in pharmacy where actual per member per month costs (PMPM) between FY 1995 and FY 1997 for pharmacy have increased by nearly 28% compared to a less than 5% increase in total PMPM costs. DMA projects a 41% increase in pharmacy PMPM costs between FY 1997 and FY 2000. This level of increase puts pharmacy services at 16% of total expenditures in FY 2000 compared to 9% of total expenditures in FY 1995.

Likewise enrollment growth in client years is estimated to have the largest growth rate between FY 1997 and FY 1998 at 12.6%. Projected enrollment growth over the health reform period is 26.8%. Much of the expenditure growth is due to the enrollment growth. A look at per member per month rates reveals that DMA is projecting an overall growth rate from FY

1995 to projected FY 2000 of about 3.8%, which is in line with budget neutrality forecasts. This may be challenging to sustain given all of the recent and continuing financial/reimbursement issues by nearly all health care providers and managed care insurers. (see Figures 9 and 10).

Expenditures: MassHealth Standard Enrolled Members
Most MassHealth Standard members are enrolled in either the Primary Care Clinician (PCC) case management plan or a Health Maintenance Organization (HMO). MassHealth recipients are offered choices among plans, but the number of participating plans has diminished for a number of reasons including market consolidation. In fact, in some geographic locations, a real choice of plans is rather limited. As of December 1999 about 78% of Standard enrollees were enrolled in the PCC plan and 22% were enrolled with an HMO.

Actual expenditures for the MassHealth Standard enrolled population in FY 1995 were more than $1.3 billion. DMA is projecting expenditure growth of nearly 30% between FY 1997 and FY 2000 to $1.67 billion. (see Figure 11)

DMA projects that the breakdown of Standard expenditures between PCC and HMO will remain unchanged at around 80% and 20% respectively. These expenditures remain consistent with the actual and projected enrollment figures (78% and 22% projected proportions in FY 2000). The non-disabled population comprises a consistent 83% of the enrolled Standard population. Table 1 shows that expenditures on the non-disabled versus disabled population are also consistent. Tables 1 and 2 clearly depict the higher expense associated with services provided to the disabled population with 17% of the enrolled Standard population accounting for 43% of the expenditures in FY 1998.

Reviewing MassHealth enrolled Standard PMPM rates provides further evidence of the difference in the expenditure for services provided to the non-disabled versus the disabled population. The PMPM rates for the non-disabled PCC population (63% of Standard enrolled members) range from the FY 1996 low of $155.70 to the forecasted high in FY 2000 of $171.41, an average increase of about 10% across five years. The non-disabled HMO rates (20% of Standard enrolled members) range from a low of $156.25 in FY 1997 to the projected high of $178.41 in FY 2000, an average increase of 14.2%. Much of this increase is due to more services moving under capitation.

The health reform period for the disabled population rates show a projected higher rate of increase for the disabled PCC population compared to the disabled HMO population. The disabled PCC PMPM rates (15% of Standard enrolled members) are projected to increase by 16.4% from $548.15 in FY 1997 to $637.98 in FY 2000. The disabled HMO PMPM rates (2% of Standard enrolled members) are projected to increase by 19.5% from $641.74 to $766.91 The projected disabled HMO PMPM rate in FY 2000 is 20% higher than the projected disabled PCC PMPM rate in 2000 (the actual FY 1997 rates were 17% higher). Overall, the PMPM rates for HMO enrollees are higher than for PCC enrollees. In only two years, FY 1997 and 1998, were non-disabled HMO PMPM rates less then the PCC rates. (see Figure 12)

Figure 9 This figure shows the trends in total MassHealth reform members and e

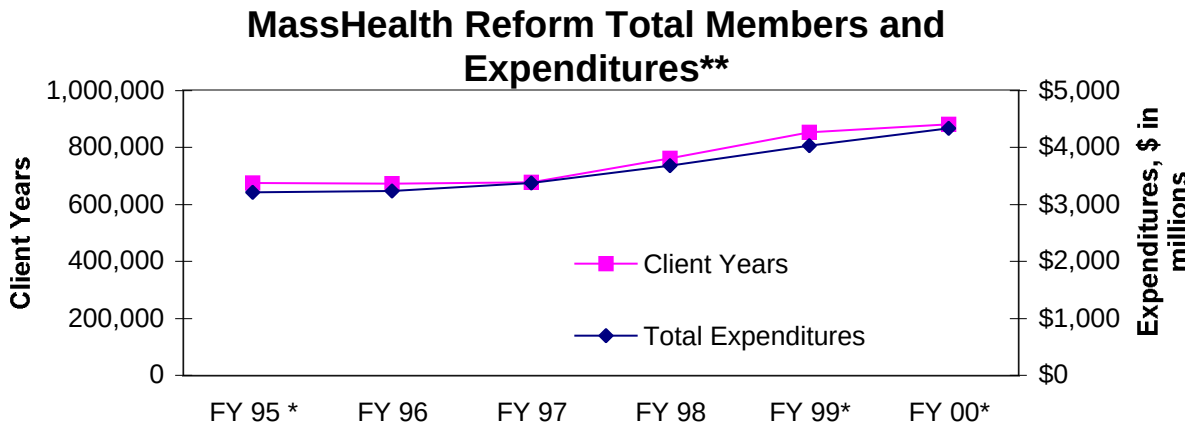
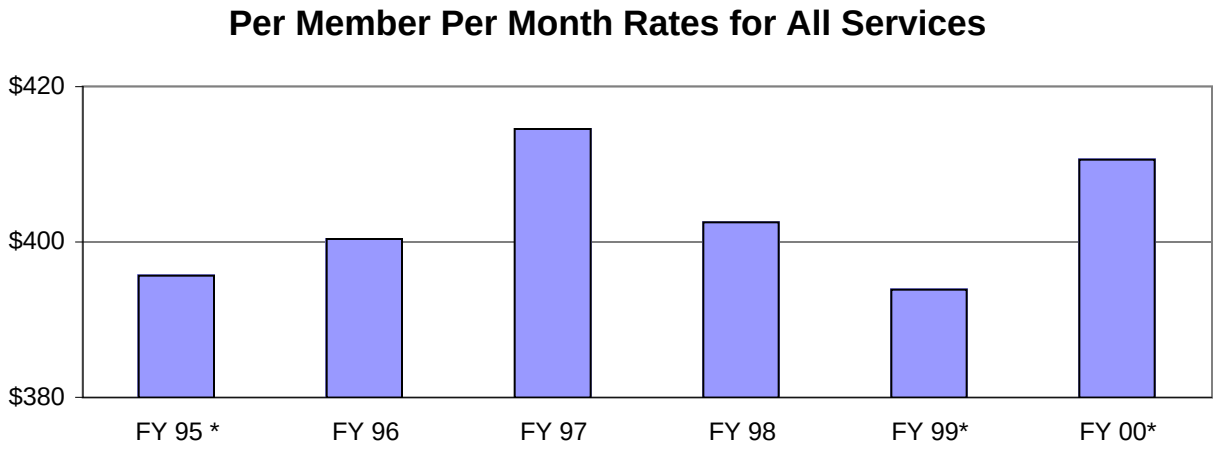


Figure 10 This figure shows the trend in per member per month rates for MassHea



Data source: DMA Budget Office Forecast Summary

* FY 95-97 are actual figures, FY98 and FY99 are estimated and FY00 is projected based on claims data.

**Expenditure data are based on date of service expenditures.

Figure 11 This figure shows the trend in MassHealth Standard enrollees expenditures.**

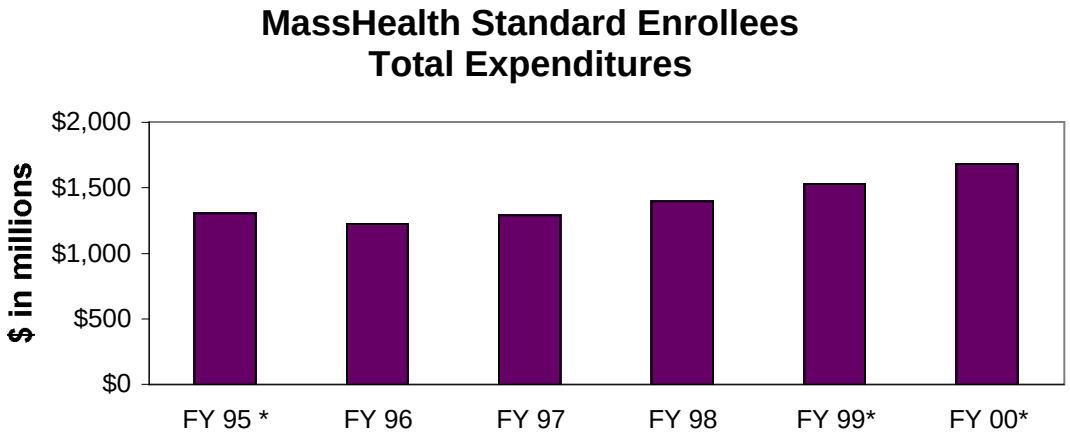
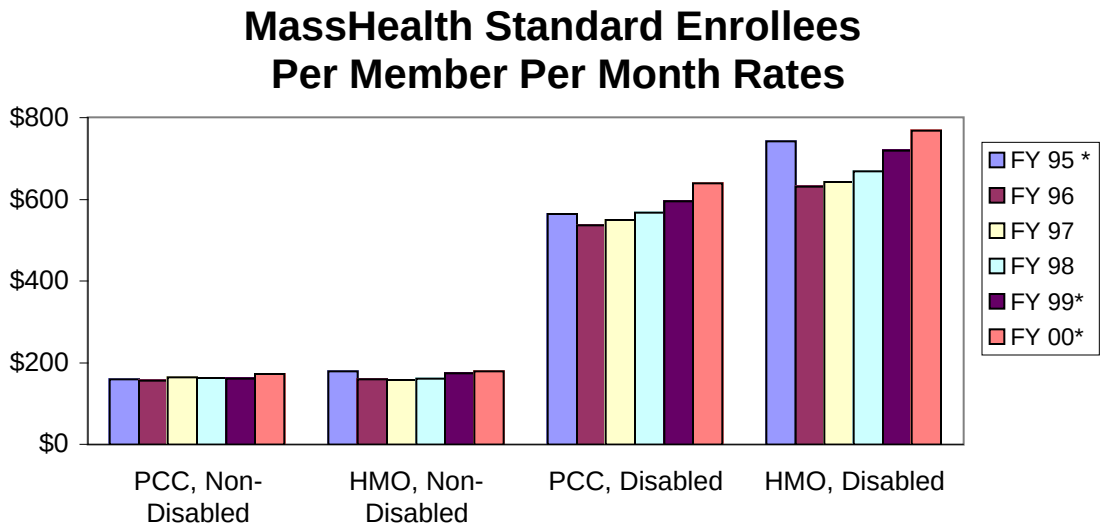


Figure 12 This figure shows the trend in per member per month rates for MassHealth Standard enrollees.



Data source: DMA Budget Office Forecast Summary

* FY 95-97 are actual figures, FY98 and FY99 are estimates and FY00 is projected based on claims data.

**Expenditure data are based on date of service expenditures.

Table 1 MassHealth Enrolled Standard Expenditures**

Percent of Total (dollars in millions)

	FY95 *	FY96	FY97	FY98	FY99*	FY00*
PCC	82.9%	84.0%	81.4%	76.7%	76.6%	79.9%
HMO	17.1%	16.0%	18.6%	23.3%	23.4%	20.1%
Non-Disabled	58.6%	57.8%	57.1%	56.8%	57.4%	57.4%
Disabled	41.4%	42.2%	42.9%	43.2%	42.6%	42.6%
Total Expenditures	$1,304	$1,220	$1,286	$1,397	$1,529	$1,677

Table 2 MassHealth Enrolled Standard Members

Percent of Total (client years)

	FY95 *	FY96	FY97	FY98	FY99*	FY00*
PCC	81.7%	82.1%	79.4%	74.9%	75.3%	78.0%
HMO	18.3%	17.9%	20.6%	25.1%	24.7%	22.0%
Non-Disabled	83.4%	82.6%	82.1%	82.7%	83.4%	83.6%
Disabled	16.6%	17.4%	17.9%	17.3%	16.6%	16.4%
Total Client Years	470,127	454,401	458,966	497,256	534,902	554,996

Data source: DMA Budget Office Forecast Summary

* FY 95-97 are actual figures, FY98 and FY99 are estimates and FY00 is projected based on claims data.

** Expenditure data are based on date of service expenditures.

Expenditure: MassHealth Basic Enrolled Members
MassHealth Basic ended its first year, FY 1998, with enrolled members costing just over $68 million. DMA projects an expenditure increase of more than 170% in FY 2000 to $183.5 million. (see Table 3) In FY 1998 estimated enrollment was 56.5% in the PCC plan with 43.5% participating in HMOs. Total client years are projected to grow by 185%. DMA is also projecting that the PCC plan will account for 69% of members and HMOs for 31% by FY 2000. (see Table 4) Total expenditures are projected to go from 61.6% PCC and 38.4% HMO in FY 1998 to 66.7% PCC and 33.3% HMO in FY 2000. (see Table 3)

In FY 1998 the Basic population HMO PMPM rate was quite a bit below the PCC PMPM rate, $282.90 compared to $348.71. However, DMA projects a 15.7% increase in HMO PMPM rates to $327.32 together with a 16.8% decrease in PCC PMPM rates to $290.11 by FY 2000. In fact, Figure 13 shows that it is only in FY 1998 that HMO rates are less than the PCC rates. Most of this is due to the change in acute care services rates as more HMO recipient services are moved under a capitated rate. Figure 14 illustrates that in FY 1998, the HMO capitation rate for acute care services was $167.13. The FY 1999 estimate of $213.85 is an increase of 28%, and DMA projects a $229.83 rate for FY 2000 acute services. The PCC acute care PMPM rate in FY 1998 is estimated at $270.78, with projections declining by 18.4% to $220.97 by FY 2000.

Utilization: Acute Hospital Visits
MassHealth reform member's enrollment volume in client years has increased nearly 26% between state fiscal years 1997 and 1999. Likewise, total Medicaid volume (these data include ages 65+) at acute care hospitals has shown increases between 1997 and 1999 (data are submitted on hospital fiscal year ends). The data shows that outpatient visits have increased more rapidly than inpatient discharges. Inpatient discharges at acute care hospitals show a decline of nearly 9% between hospital fiscal years (HFY) 1995 and 1996. Both inpatient and outpatient visits grew by similar proportions between HFY 1996 and HFY 1997, 3.5% and 4.1% respectively. Over the next two years both inpatient and outpatient Medicaid utilization at acute care hospitals show steady growth increases. Overall, Medicaid inpatient discharges increased 16% and outpatient visits increased by 34.7% between HFY 1997 and HFY 1999. (see Figures 15 and 16) One reason for the more significant increase on the outpatient side is the national trend of hospital services moving from inpatient to outpatient settings.

The data also shows that between HFY 1997 and HFY 1999, while Medicaid utilization was increasing, utilization for the uninsured (self-pay) decreased. Inpatient discharges for the uninsured declined by 29.7% and uninsured outpatient visits declined by 11.6%. Figure 17 shows that while both Medicaid and uninsured inpatient volume was declining between HFY 1995 and HFY 1996, the uninsured volume continued to decline at a similar rate as the Medicaid increase in later years. (see Figures 17 and 18)

Utilization: Preventable Hospitalizations
Preventable hospitalizations (PH) or ambulatory care sensitive conditions are those for which

Table 3 MassHealth Enrolled Basic Expenditures**

Percent of Total (dollars in millions)

	FY98*	FY99	FY00*
PCC	61.6%	60.5%	66.7%
HMO	38.4%	39.5%	33.3%
Total Expenditures	$68.23	$159.16	$183.50

Table 4 MassHealth Enrolled Basic Members

Percent of Total (client years)

	FY98*	FY99	FY00*
PCC	56.5%	61.7%	69.3%
HMO	43.5%	38.3%	30.7%
Total Client Years	17,763	43,147	50,712

Data source: DMA Budget Office Forecast Summary

* FY98 and FY99 are estimates and FY00 is projected based on claims data.

**Expenditure data are based on date of service expenditures.

Figure 13 This figure shows the per member per month rates for enrolled Basic members.

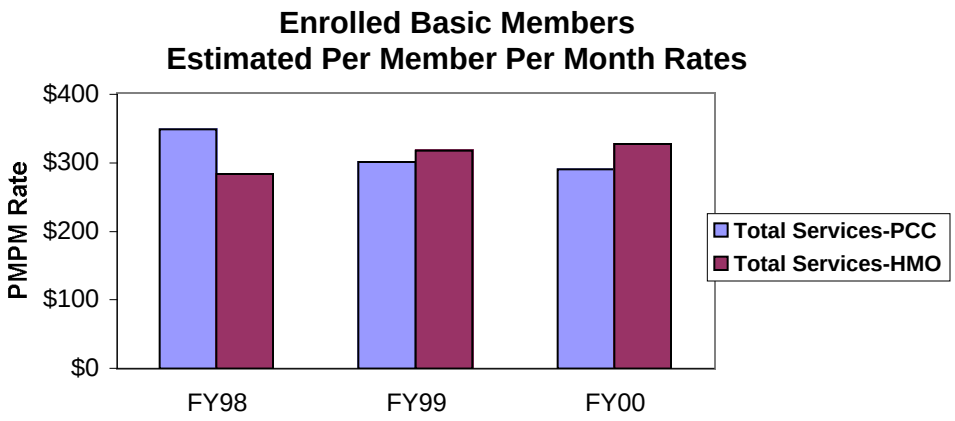
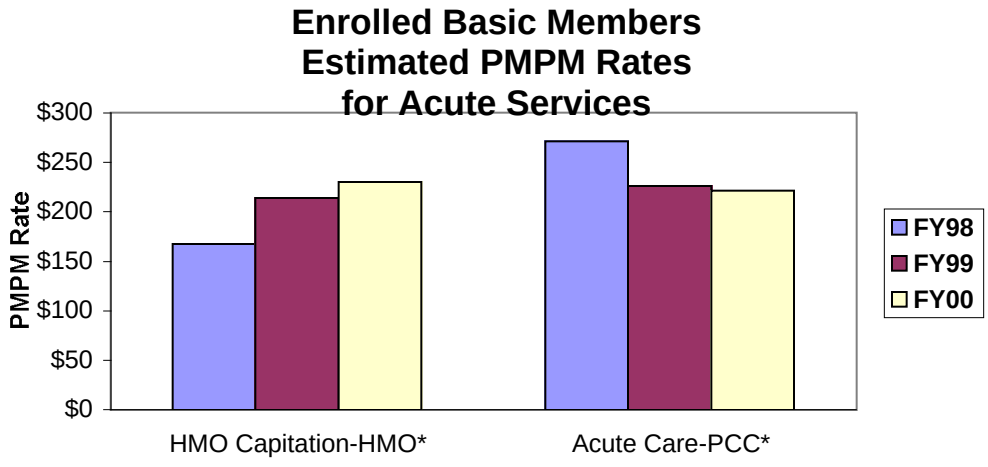


Figure 14 This figure shows the estimated per member per month rates for enrolled Basic members acute services.



*does not include MH/SA rates

Data source: DMA Budget Office Forecast Summary

* FY98 and FY99 are estimates and FY00 is projected based on claims data.

**Expenditure data are based on date of service expenditures.

Figure 15 This figure shows the trend in percent changes in total* Medicaid utilization at Massachusetts acute care hospitals.

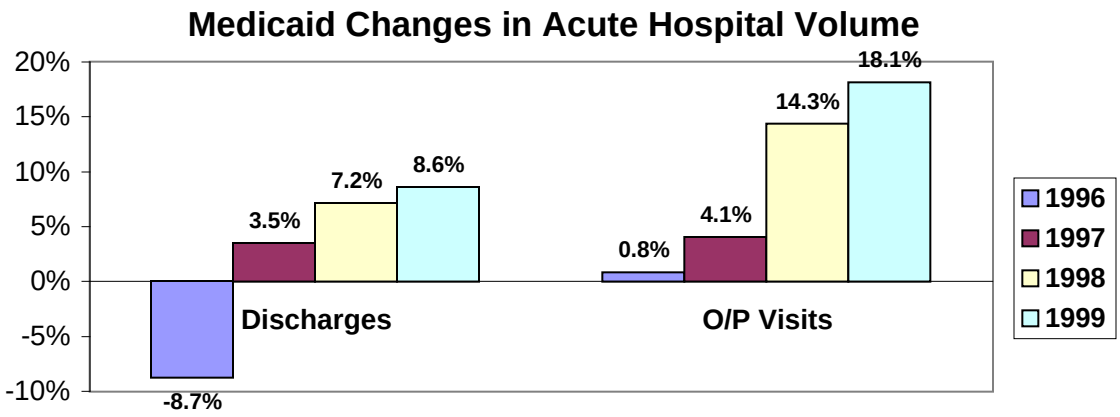
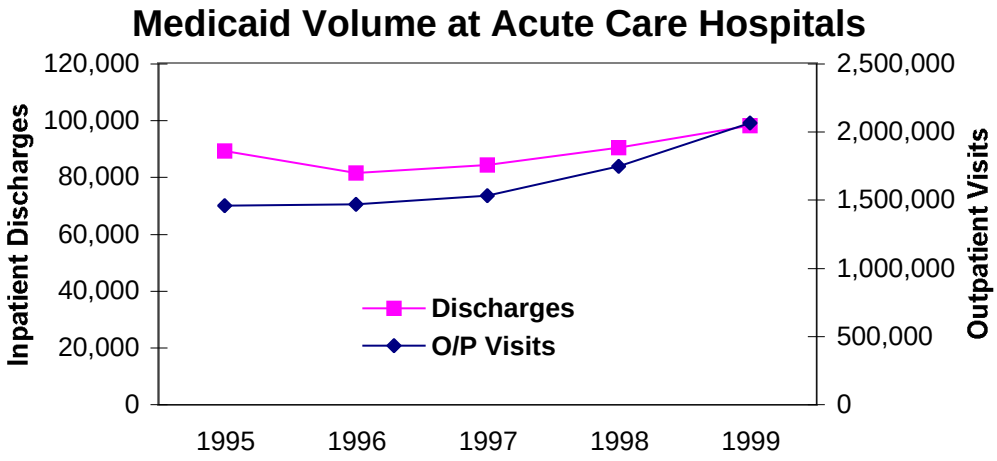


Figure 16 This figure shows the trend in total* Medicaid utilization at Massachusetts acute care hospitals.



Data source: DHCFP Hospital Cost Reports

*total includes the elderly

Figure 17 This figure shows the trend in Medicaid and Uninsured Discharges.

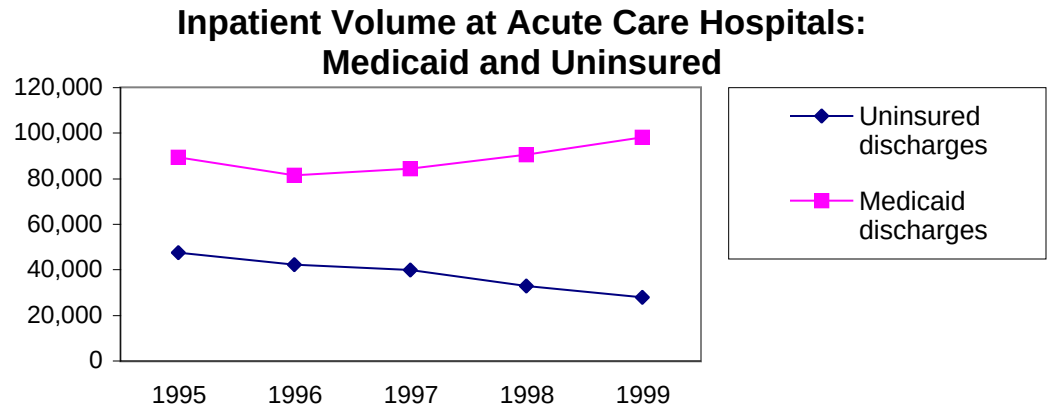
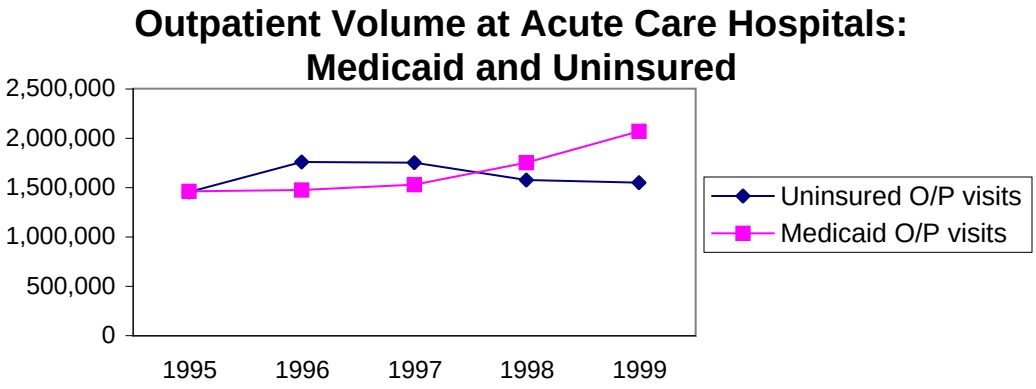


Figure 18 This figure shows the trend in Medicaid and Uninsured Outpatient Visits.



Data source: DHCFP Hospital Cost Reports

timely and effective primary care will reduce the risk of hospitalization. Some examples of PHs include asthma, bacterial pneumonia, chronic obstructive pulmonary disease and congestive heart failure. The data used in this report is based on a total of 24 ambulatory care sensitive conditions.[vi]

In general, PH rates have been declining over the past few years. PH discharges for Medicaid ages 0 – 64 shows a very steady decline between 1994 and 1996 dropping by 29.6%, with a general leveling off between 1996 and 1998 (-1%). PH discharges for children between the ages of 0 – 17 declined by 38.2%, and again by 10.4% during these same time periods. The uninsured also show a decline in PH discharges, and it is interesting to note that the uninsured PH discharges proportionately declined more from 1996 to 1998 (-29% ages zero to sixty-four and –39% ages zero to seventeen) than between 1996 and 1994 (-21.8% and –30% respectively). (see Figures 19 and 20)

Another way of looking at the change in PHs is to examine how Medicaid as a percentage of total PHs has changed over time. Data was averaged over two years to provide more reliable proportions. For ages 0 – 64, Medicaid as a portion of total PH discharges stayed consistent with a marginal decline from 21.01% to 20.58%, and declined for ages 0 – 17 from 31.35% to 28.91% of total PH discharges between FY 1995/1996 and FY 1997/1998. (see Figures 21 and 22)

It is difficult to make direct conclusions regarding this information given all of the complex interactions and changes in the provision of health care services. For instance, it is well known that the provision of health care services has been shifting from acute hospital inpatient to outpatient services. And there is a relatively new reimbursement methodology commonly used now, observation stay or beds. Observation stays do not have one consistent definition, but are considered outpatient services, and may influence the data trends. However, the data does suggest that, keeping in mind rapidly increasing MassHealth enrollment, acute hospital utilization and preventable hospitalizations appear reasonable.

V. Quality and Customer Satisfaction

Quality

The Division of Medical Assistance uses a number of tools and methods to assess and monitor health plan quality and member satisfaction. Specific quality standards are incorporated into the Managed Care Organizations (MCO) contracts, and quality management objectives for the Primary Care Clinician (PCC) Plan are developed in a collaborative process with DMA and the PCC Plan providers. The MCO program focuses on quality improvement and measurement in four areas: MCO contract status meetings, member satisfaction surveys, Health Plan Employer Data and Information Set (HEDIS) measures, and MCO clinical topic reviews. MCOs have standard improvement goals in addition to plan specific goals. In state fiscal year 1999 standard goals for MCOs included improvements to the enrollment process and access to covered services, a joint goal with the PCC Plan around perinatal and well-childcare, care management for at risk populations, and behavioral health service delivery improvements. Individual MCO plan goals are negotiated with each MCO and may address clinical initiatives, network development, and/or specific populations. PCC

Figure 19 This figure shows the trend in Preventable Hospitalizations for ages 0-64

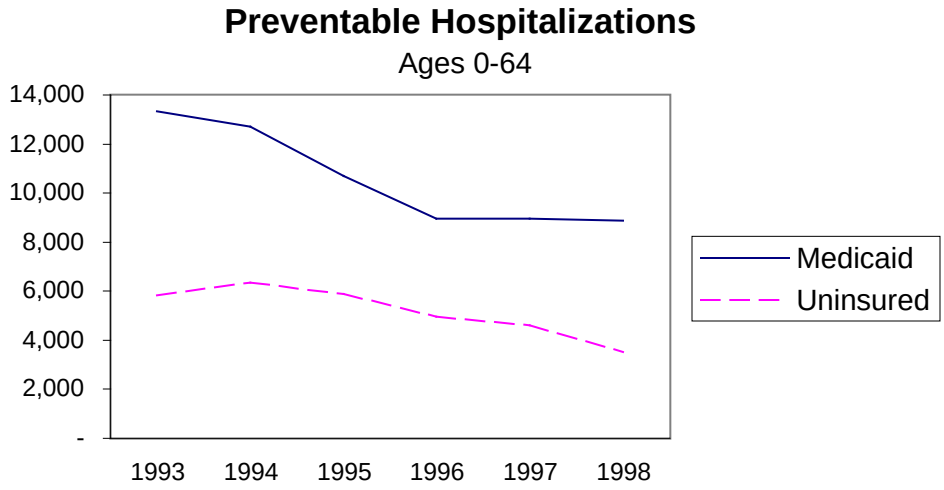
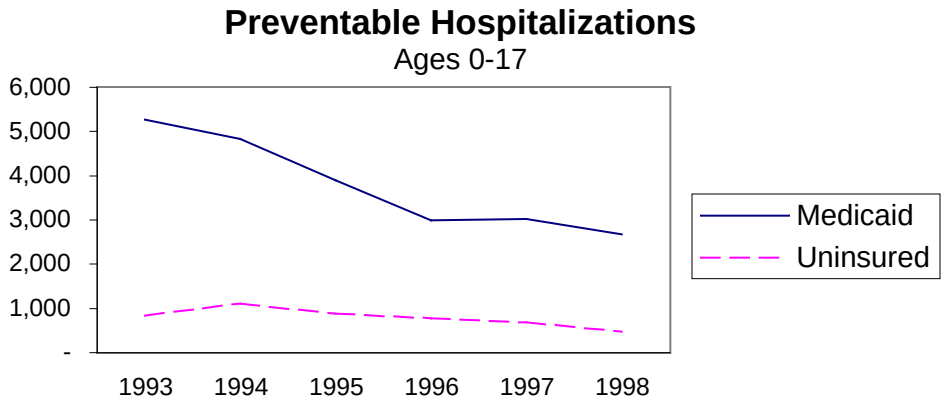


Figure 20 This figure shows the trend in Preventable Hospitalizations for ages 0-17



Data source: DHCFP PH Database

Figure 21 This figure shows the proportion of Medicaid and Uninsured PHs to total PHs for ages 0-64

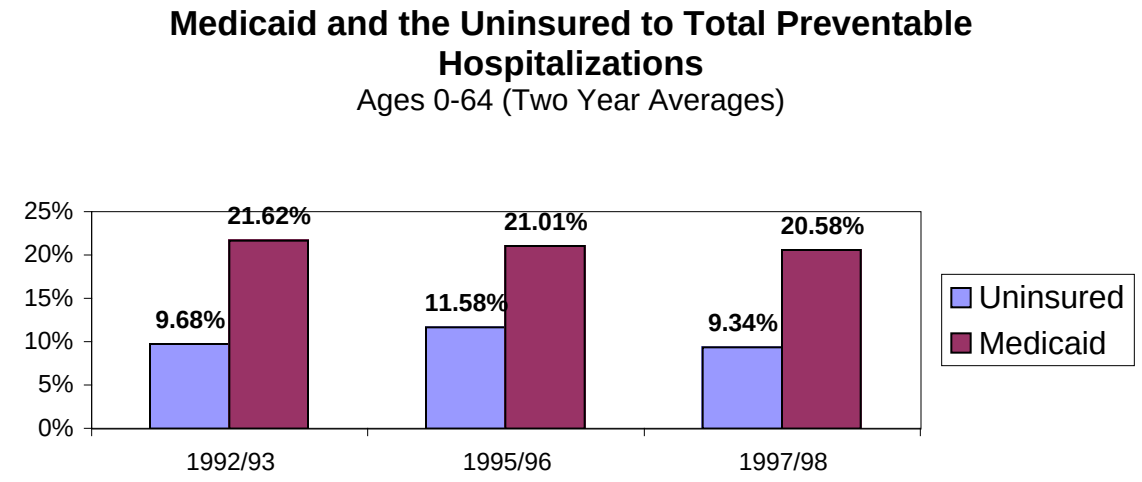
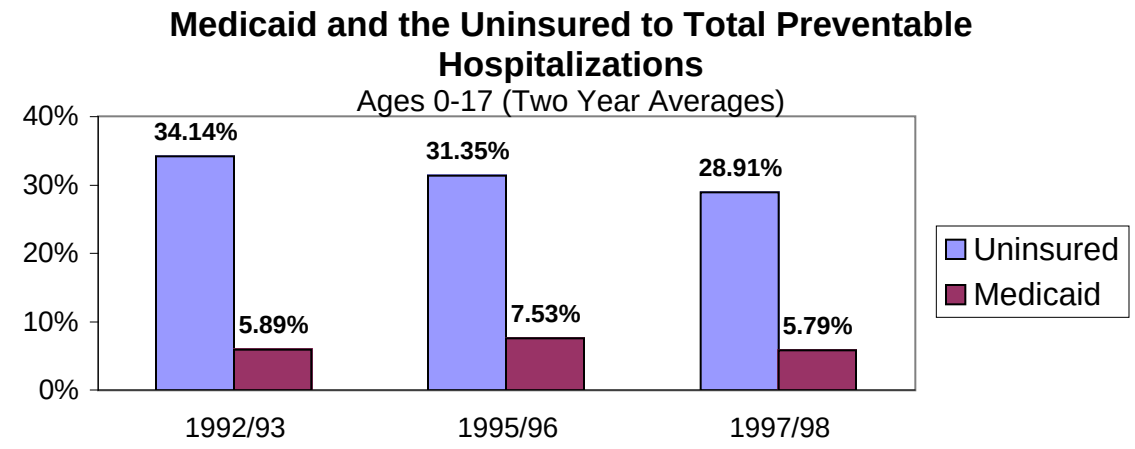


Figure 22 This figure shows the proportion of Medicaid and Uninsured PHs to toatl PHs for ages 0-17



Data source: DHCFP PH Database

plan goals are developed after assessing data from three sources: aggregate PCC data, HEDIS measures and the MassHealth Member Survey. The PCC Plan 1999 goals focused on improvements in asthma care, well childcare, cancer screening for women coordinating primary and behavioral health service and prenatal care.

HEDIS

The Health Plan Employer Data and Information Set (HEDIS) is a standardized measurement and reporting methodology for health plans and managed care organizations directed by the National Committee for Quality Assurance (NCQA). It is a national effort to develop a set of quality measures that will be consistent over time with sufficient detail to be comparable among health plans. DMA uses a subset of HEDIS measures on a rotating basis to assess the performance of all MassHealth plans. DMA staff work with internal and external stakeholders to select the subset of HEDIS measures each year. Specifications may be modified where DMA determines it is clinically significant. For example, two additional well-child measures that are not included in the HEDIS set of measures were created that coincide with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines. The strategy of rotating measures allows plans time to use the results to aid in evaluating performance improvement activities initiated in response to the previous HEDIS findings. It also reduces the burden of data collection on the health plans. After several years of requiring plans to collect the full set of measures, NCQA has introduced its own rotation strategy for HEDIS 2000.

The HEDIS 1999 measures are broken down into three performance domains: Effectiveness of Care, Access/Availability of Care, and Use of Services. The measures collected for the MassHealth HEDIS 1999 focus mainly on well-child and behavioral health services and fall into each of the three performance domains. The six measures are: well-child visits, adolescent well-care visits, children's access to primary care providers, mental health utilization, chemical dependency utilization, and follow-up after mental illness. DMA issued a report on December 20, 1999 that includes a large proportion of the data collected. Data collected are based on the services provided to MassHealth managed care enrollees during calendar year 1998. Seven health plans participated. The seven plans along with their respective MassHealth enrollees as of December 1998 are:

- Boston Medical Center HealthNet Plan (BMC), approximately 13,100 MassHealth members, began operations in July 1997
- Fallon Community Health Plan (Fallon), serving about 14,600 MassHealth members
- HPHC serving about 46,500 members
- Kaiser Permanente Northeast Division with 3,700 members, Kaiser ceased services to MassHealth members effective July 1999
- Neighborhood Health Plan (NHP), approximately 56,900 MassHealth members
- Network Health (Cambridge Health Alliance), 6,900 MassHealth members, began operations in July 1997 and
- PCC Plan with approximately 383,300 MassHealth members as of December 1998.

HEDIS 1999 Summary of Results

In general, the MassHealth managed care plans compared favorably to regional and state commercial MCO plans, as well as to the applicable *Healthy People 2000* goals. Additionally

this year national Medicaid benchmarks from 21 states and 109 Medicaid health plans are available for the first time through the American Public Human Services Association (APHSA) Medicaid HEDIS Benchmarking Database project. The MassHealth managed care plans on average performed much higher than the applicable APHSA benchmarks. Also, MassHealth managed care provides a higher proportion of children and adolescents with well-care and access to primary care providers than commercial MCOs nationwide. The benchmark that may be most comparable for the MassHealth results is the Massachusetts commercial MCOs. According to the NCQA Quality Compass (a collection of commercial HEDIS results submitted to NCQA by MCOs nationwide), the Massachusetts commercial MCOs are among the best in the country. There seems to be room for some improvement, however, in the performance of the MassHealth MCOs compared to the commercial MCOs, but again it is important to remember that these results are not risk adjusted. MassHealth managed care performance on the mental illness measure: follow-up after hospitalizations for mental illness is better than the HEDIS Massachusetts rate and comparable to the HEDIS national rate.

There was variation in results between the MassHealth managed care plans. This suggests that there is room for improvement in the quality of health care provided to MassHealth members. See the appendix for the Executive Summary of Performance table from the *HEDIS 1999 Report.*

The DMA report lists the implications and usefulness of the results, along with the caveats and limitations of the data. A sample of the caveats include the following:

- Measures are not fully comparable across plans. HEDIS does not provide for risk adjustment across populations at this time.
- Plan sample sizes vary, which impacts comparability of data between plans. For example the PCC Plan size is so large compared to the other plans, its performance is weighted more heavily when calculating means. Thus DMA also calculated the median values to obtain a clearer picture of average plan performance versus average eligible enrollee performance. For some specific measures, plan sample sizes were not large enough to calculate reliable estimates.
- Many providers will have contracts with more than one plan while others will provide care in only one plan.
- There is a limited availability of benchmarks for the Medicaid population making interpretation of results challenging.

MassHealth Member Survey
DMA conducts an annual member survey to obtain feedback from MassHealth recipients on a number of areas including availability and access to services, utilization and experience with health providers, as well as satisfaction with the services delivered by their health plan or provider. The most recent survey (1998-1999) was conducted by the Center for Survey Research at the University of Massachusetts in Boston using the Consumer Assessment of Health Plans Survey (CAHPS) instrument. NCQA uses CAHPS for its Member Satisfaction Surveys and the Health Care Finance Administration uses it to survey Medicare beneficiaries enrolled in managed care plans. A brief series of questions regarding behavioral health services, family planning, and difficulty communicating with doctors due to language were

added at DMA's request to the core question set. The survey instrument was available in both English and Spanish.

Eligible respondents were adults and children who have been enrolled for at least six consecutive months as of November 1998 in one of the plan options available to MassHealth members in 1999. Members from the PCC Plan and from all contracted capitated MCOs were sampled. A total of 8,170 members were mailed surveys. There was an overall response rate of 52% consisting of 3,605 surveys returned by mail and another 1,450 completed by telephone. There was a minimum of 500 members sampled from each plan.

The purpose of the CAHPS report is to compare the data regarding experiences of people who belong to the various MassHealth plans. As a result, the primary question is whether the experiences reported by members of any particular plan were distinctively different from others. These differences are designated in the report when the responses for a particular plan are statistically different from the median of responses from all of the plans. Many factors, including sample size and member characteristics of the plan, need to be taken into consideration when interpreting these differences. The following survey result summaries represent the major components of the report.

MassHealth Member Survey Results: Communication
Member characteristics such as race, education and language vary across plans. Adult members of NHP report significantly more problems than the median of all plans understanding health care providers because they spoke a different language, while HPHC members report significantly fewer problems. Children members at BMC HealthNet Plan and Network Health are most likely to report a difficulty in communication associated with language.

Member Survey Results: Mental Health Services
Only a small percentage of respondents reported that they sought mental health services and the number of responses for children was particularly small. Responses to needing treatment or counseling and how much of a problem it was accessing services varied quite a bit. Only BMC HealthNet Plan adult members said there was some problem getting treatment or counseling at a rate statistically lower than the median. Across all plans the rates of reporting some problem in getting mental health services tended to be higher than the comparable rates for getting medical services.

Member Survey Results: Composite Measures of Experience
The CAHPS instrument suggests combining related or same topics to form multi-item indices for patient experiences. There are five such indices. A sample of two of these indices are presented here:

- Getting Care Quickly consists of four items: getting help or advice needed when called during regular office hours, getting an appointment for regular or routine care as soon as wanted, getting care for an illness or injury as soon as wanted, and waiting in doctor's office or clinic more than 15 minutes past appointment time.

Adult members of BMC HealthNet Plan, Network Health, and Kaiser all scored significantly below the plan median for this composite. According to the survey results, children who belong to HPHC and the PCC Plan had experiences significantly above the median, with Kaiser members again significantly below the median.

- Getting Needed Care also consists of four items: getting a personal doctor or nurse you were happy with, getting a referral to a specialist you needed to see, getting the care you or your doctor believed necessary, and having delays in health care while waiting for approval.

The answers to these questions ranged from: a big problem, a small problem, or not a problem. Adult Fallon members reported a significantly more positive experience than the median. Fallon members were also significantly more positive about getting care for children. PCC Plan members also reported significantly fewer problems in getting care for children than the median while BMC HealthNet Plan members reported significantly more problems getting care for children.

Member Survey Results: Ratings of Providers
The CAHPS instrument has respondents rate from 0 to 10 (worst to best) the providers and health care services they have received. BMC HealthNet Plan received ratings significantly higher than the median for adults, and Network Health was significantly higher than the median for children for the ratings for personal doctor or nurse. The rating for personal doctors for adults in Kaiser was significantly lower than the median.

Member Survey Result: Conclusion
The conclusion of the DMA report states that in general members who have serious health problems or speak languages other than English often report more negative experiences with their health care. The MassHealth plans member characteristics differ in ways that may be associated with their ratings. MassHealth is well aware of the importance of cultural/language issues and ensures that cultural competency is an integral part of business in the Member Services Unit.

Grievances and Appeals
Grievances are filed with the MassHealth Member Services Unit. In state fiscal year 1999, only 470 grievances were filed for the MassHealth population representing well under .01% of MassHealth members. There were a total of 3,262 appeals of eligibility decisions, representing less than .07% of the MassHealth population.

V. Results of Interviews with Key Stakeholders

In addition to conducting empirical analyses using available data, an independent consultant also interviewed key stakeholders to learn more about their perceptions of the impact of health reform on MassHealth. The individuals interviewed for this part of the report were purposively selected to represent specific points of view of stakeholders who have an interest in the outcome of health reform. They are not necessarily representative of the population of all stakeholders in the state. Nonetheless, their perspectives add another perspective toward understanding the impact of health reform. The interviews were

conducted during Spring, 2000 and the information gathered represents perceptions at that point in time. In this section of the report, we provide a summary of the issues raised during these interviews. Results of interviews are organized according to the following major topics:

- Enrollment, including the process of enrollment, enrollment trends, barriers to enrollment, and eligibility redeterminations;
- Provider and program issues; and
- The future of MassHealth.

Enrollment:

The Enrollment Process

The process of enrolling individuals into MassHealth typically begins with outreach to uninsured populations. DMA employs 24 outreach workers, in four regional offices across the state. The role of the DMA outreach worker is to go to hospitals and health centers in his or her region to educate provider staff about how to complete MassHealth Benefit Request Forms (MBRs). Outreach workers also meet with staff at the provider location to help them complete MBRs and to screen completed applications to make sure they contain all the necessary information.

In addition to DMA outreach workers, there are also MassHealth enrollment outreach workers sponsored by DMA/DPH mini-grants and some by Neighborhood Health Plan. The outreach workers reported that there is not duplication in the activities conducted by these different outreach workers, since they focus on different steps in the process of helping someone become eligible for MassHealth.

Individuals complete an MBR to apply for MassHealth benefits, often with the assistance of an outreach worker or staff at provider locations. In the past few years DMA has made efforts to simplify and shorten the MBR.

Everyone interviewed for this report affirmed that as a result of health reform there has been dramatic growth in the population that receives MassHealth benefits. DMA has worked diligently to improve the eligibility and enrollment process. Interviewees also agreed that providers have played an instrumental role in encouraging enrollment in MassHealth. Respondents reported that health reform has “pulled in so many people” that outreach will now become more challenging, because the uninsured populations now comprise people who are more difficult to reach.

MassHealth Basic Enrollment

A new eligibility category implemented as a result of health reform is MassHealth Basic. This eligibility category provides coverage for those who are long-term unemployed. Over the last two years respondents reported that it has been easier to access hearing aids and eyeglasses benefits, which were major needs for the homeless population. These respondents reported that the benefit package is “better now” than it was when the first MassHealth evaluation was completed. Actually, the benefit package for Basic members has not changed during this period.

The MassHealth Basic population includes some individuals who are homeless. At the time of the interviews, the proposed state budget included about five million dollars to further expand MassHealth eligibility, including additional coverage for the homeless population. A DMA interviewee estimated that there are about 3000 people who are homeless covered under MassHealth Basic. The Massachusetts Coalition for the Homeless estimates that about 10,000 people are homeless in Massachusetts. The proposed budget would deem additional people who are homeless eligible for MassHealth using the homeless definition in the McKinney program. This is a somewhat less strict definition of homelessness, but one that still meets federal requirements.

It is a challenge to follow through with people who are homeless to help them become eligible for MassHealth benefits; it is difficult for this population to provide the necessary paperwork and the transient nature of the population makes it nearly impossible to conduct eligibility determination procedures through the mail. “People move on to other settings before eligibility determination can be completed.”

Barriers to Enrollment

Despite the success in increasing enrollment, interviewees identified several barriers to enrollment in MassHealth. For example, some respondents reported that the biggest barrier to completing MBRs is language. Providers explained that they are serving more people who speak a greater variety of languages than ever before. The MBR has not been translated into these other languages and so it is a time consuming process to complete. Providers reported that they carry the burden of translation themselves and do not receive enough support from DMA for translation services.

Other respondents reported that there are only minor issues of cultural competence in completing the MBR. In many regional offices there are outreach staff who speak multiple languages. “Language issues tend to be regional,” and are somewhat related to the provider infrastructure of the region. For example, in Lowell, the community is “stronger” and workers know each other well, making outreach and connections among agencies easier.

While one respondent found the MBR is “so basic that people think they need to provide more information than they are required to provide”, another found the MBR an “embarrassing document.” Although DMA has improved this document over the course of health reform, some feel it is still too long. Respondents reported that the MBR is challenging for some of the difficult to reach populations because these individuals are not able to answer even simple questions. Sometimes provider-based outreach workers have difficulty getting information from clients.

MassHealth Eligibility Redetermination

When the federal government decoupled welfare and Medicaid eligibility decisions, DMA assumed the responsibility of conducting regular eligibility redeterminations for MassHealth benefits as required by federal and state laws. DMA began redeterminations by reviewing the population of eligibles who were receiving Medicaid benefits before health reform. DMA has tried to set up a “friendly system” for redetermination: DMA mails beneficiaries four notices, and gives them 79 days to respond. In addition, outreach workers are calling PCC enrollees. DMA has also given the names of those being redetermined to the HMOs and to BMC and

Cambridge Health Alliance so these providers know who is being redetermined. These facilities have contacted individuals being redetermined in advance and have had some success in helping people to re-enroll in MassHealth.

Provider and advocacy representatives are frustrated with the redetermination process: just as some individuals gain MassHealth eligibility, others lose eligibility through redetermination. Providers believe they are spending much of their outreach efforts helping people through the re-determination process, rather than helping new people enroll in MassHealth. Although some respondents believe this approach is excessively disruptive to recipients, most recognize that Medicaid is a means tested program. Means testing requires that some people will "fall off the program" as they gain insurance or employment. Individuals do acquire health care coverage, or they move, or do not perceive that they need health care coverage, and so they do not re-apply for benefits. Some of these individuals will "resurface" when they need health care coverage again. One implication of this process is that people disappear when they do not need coverage and resurface when they do need insurance; this may result in adverse selection for MassHealth and health plans. Interviewees were concerned that a side effect of redetermination may be an increase in Pool utilization.

According to interviewees, DMA's experience is that 30% of people who go through re-determination are not re-enrolled, although the non-response rate is higher for the Basic population. Interviewees were not certain why recipients do not re-enroll in Medicaid if they are eligible to do so. One issue identified in interviews is the language barrier – people who do not speak English do not understand the redetermination documents.

One respondent suggested that there should be closer coordination between DMA and DHCFP around redetermination, since people may be shuffling between MassHealth and the Pool during redetermination and afterward.

Two recommendations that were offered from respondents regarding redetermination are:

- Redetermination should not be conducted by mail: "Based on all our experience in this state, we know that direct outreach is important in getting people to enroll in MassHealth. We have learned from Health Reform that one-on-one contacts are the best way to enroll people in MassHealth." Many times individuals need interpreters, or else "they just don't understand the process."
- If DMA does continue to redetermine eligibility by mail, DMA should mail the redetermination application with current eligibility information printed on it, so that it will be easier for recipients to return.

In response to these concerns, DMA is piloting mailing out application materials with a pre-stamped envelope. They are also considering whether it is feasible to mail out MBRs with pre-printed recipient eligibility information.

The Churning Issue

Several respondents indicated that the stream of people applying for MassHealth churns with people gaining and losing MassHealth eligibility as well as other types of insurance. This population includes individuals who gain and lose employment, part time workers who do

not have health insurance as an employment benefit and people who work in the service industry. People's income and insurance status frequently changes, and there are constantly people who need to apply and re-apply for MassHealth. Interviewees reported that the churning causes operational and care management issues for providers and managed care plans and may also have a negative impact on patients. Interviewees suggested this issue may be one of the reasons the private HMOs have backed away from serving the Medicaid population; the churning effect is expensive for HMOs.

One respondent suggested that there should be a multi-agency response from the relevant state agencies to prevent lapses in coverage. In addition, perhaps policymakers should be rethinking eligibility requirements to reflect the changing income and insurance status of the target population.

Individuals who have been involved with health reform for a longer period of time reported that they thought that by entitling more people, there would be less of a "churning effect". To their surprise, the churning effect is continuing.

Provider and Program Issues:
MassHealth and Community Health Centers
Overall, as a result of health reform, the Community Health Centers (CHCs) have experienced an increased "revenue bump." However, there is great variation among CHCs in their experience under health reform. For example, Greater Lawrence Health Center was able to enroll a large proportion of their previously uninsured patients into MassHealth. Once these individuals became eligible for MassHealth, they also chose the Center as their primary care site. Thus the Center has been able to increase revenue from MassHealth. Other CHCs have not been as successful in "converting" patients to MassHealth and then retaining them in their patient population.

All Health Centers have experienced a growth in Medicaid; at some Centers enrollment in MassHealth has increased by 30%. Much of the increase is for Neighborhood Health Plan (NHP) enrollees. There is anecdotal evidence that the number of fee for service (FFS) visits at the CHCs has decreased.

Provider Reimbursement Rates
Most providers interviewed complained about the low rate of reimbursement they receive from MassHealth: providers have experienced a "decade of cost controls." Other respondents argued that there are still unnecessary costs in the system. Complicating this issue is the fact that the federal government is changing provider reimbursement strategies also, particularly with respect to the Balanced Budget Act. Respondents suggested that overall financial health of providers is not an issue solely for Medicaid policymakers; it would be worthwhile to establish a link among all the provider reimbursement issues for the legislature, so that the issue of Medicaid rates can be addressed in context.

There is some variation in the rates the CHCs receive from different payers. For example, the rate that NHP pays CHCs is a little lower than the PCC rate. But, interviewees reported that NHP has always had a good relationship with the health centers, and NHP enrollees account for 40% to 60% of MassHealth revenue for many centers. NHP is conducting a major rate

revision phase right now, after having the same rate for two years. In addition, the rate that Medicaid pays the CHCs has been flat. For example, the case management fee is $6 per visit, which is the same rate that has been in effect since 1993. The PCC rate is somewhere in the mid-$80's for a typical CHC visit. However, respondents reported that real costs for the CHCs are $5 - $10 higher. MassHealth has added some new codes for billing for the CHCs, which has helped increase Medicaid revenue somewhat. DMA has also proposed increasing the PCC enhanced rate paid to CHCs in the House 1 budget.

In general providers perceive that MassHealth rates are lower than NHP, the Pool, and Medicare rates. Many providers are operating on a deficit; this trend cannot continue for safety net providers because they argue they are operating "too close to the margin." However, it is also important to remember that Medicaid has limited resources and was known as the "budget buster" not too long ago and still has the potential to be known this way again. It is a very fine line between covering people and maintaining budgetary commitments.

Quality Outcomes

Most respondents said they didn't know whether health reform has impacted overall health status or quality of life for Massachusetts residents. One interviewee suggested, however, that there has been an improvement in some health status indicators. For example, there has been a drop in violence and a drop in teen pregnancy. One interesting outcome of the drop in teen pregnancy is that the volume of patients requiring obstetrical services at safety net providers is down and this is "hurting a number of providers".

Neighborhood Health Plan

Partly as a result of health reform, Neighborhood Health Plan enrolls the largest number of Medicaid enrollees of all managed care plans that contract with MassHealth. When health reform began, NHP had an enrollment of 45,000 members. Currently, enrollment has grown to 109,000, and about 90% of these enrollees are Medicaid eligible. The remaining 10% are commercial enrollees through the GIC, the City of Boston, some hospital employers and NYNEX; NHP has no Medicare enrollees. A large group of enrollees, about 30,000, joined NHP as a result of being transferred from HPHC. In addition, DMA's policy of encouraging enrollment in capitated plans has helped NHP's enrollment increase. Much of NHP's growth, including the Basic population, has occurred outside of Boston. In addition to enrolling the general Medicaid population, NHP focuses on special populations. For example, they have just started a managed care program for 15 children with special health care needs who are in the care of DSS. NHP provides services for these kids, including a Nurse Practitioner on site at the foster home; this reduces the need for ambulance trips to the hospital if a medical emergency occurs.

About 8000 of NHP's new enrollees are eligible for Medicaid through the Basic package. NHP does not provide all Medicaid benefits to the Basic population, and so the plan does not have the "full picture" of utilization by this group. Behavioral health benefits are provided by the Partnership and Medicaid provides pharmacy benefits directly. This may increase the perception on the part of the providers that Basic offers a more limited benefit package which has been a source of frustration for NHP clinicians who feel they cannot really coordinate

care for this population. However, NHP has found that the expenses for the Basic population have stabilized over the time that they have been enrolled in NHP.

DMA and Division of Transitional Assistance Coordination
DTA and DMA are working to develop an automatic file match of people who have been denied welfare benefits so they can be screened for MassHealth eligibility. The automatic system will be available in the fall. When the system becomes operational, clients will not be required to complete an MBR. Criticism leading up to this had been the lack of coordination between DTA and DMA. For example, one respondent reported that when someone is determined to be ineligible for welfare benefits, they might still be eligible for MassHealth. However, the welfare workers do not consistently take the extra step of determining MassHealth eligibility at the point welfare eligibility is determined. This has had the effect of possibly missing the opportunity to enroll some people in MassHealth. In addition, it has pushed the burden of enrolling people into MassHealth onto providers and may have added expense and inefficiency to the enrollment efforts.

When people leave welfare, DTA tries to provide information about other forms of support that are available. For example, they are offered a list of phone numbers for different support services. In addition, DTA has an ISA with DPH for a program called "For Families." "For" stands for Follow up, Outreach and Referral. This is a program of outreach to families who are no longer eligible for welfare benefits; when families come off welfare, outreach workers refer those that seem to need additional help to this program. The hope is that the program will connect them back to DMA if appropriate, an "indirect connection back to DMA".

Others suggested that over the last five years, DTA has changed its focus and is moving families into paid employment. DTA realizes that families need support to make this transition, and thus access to health insurance is a key factor in transitional success. The availability of health care coverage is "essential to our success." One respondent reported that three-quarters of the people who are denied welfare benefits are denied benefits because they have not followed through on completing the application and providing the information necessary for eligibility determination.

Insurance Partnership
Nearly all of the individuals interviewed for this report expressed interest in the Insurance Partnership Program (IP). But, as one respondent said: "The IP is a big unknown." Respondents realize that it is "still too early to see the impact of this policy" but at the same time, "the IP is the toughest part of health reform." DMA has just started to put more energy into the IP; as one respondent suggested little activity happened the first year, and as a result "the enrollment in the IP has not been as great as hoped." Some suggest that "this outcome could have been predicted based on how the program was set up and who was targeted." As one respondent suggested, "it is difficult to integrate public insurance with private employers."

The IP has two main components: premium assistance and payments to employers. An important implementation issue will be encouraging employers to participate in the program. As one interviewee said, "Is there enough incentive for employers to participate?" According to DMA, incentive payment amounts have not increased since they were first formulated in

1994 whereas health insurance premiums have increased. DMA has contracted with an intermediary, Employee Benefit Research Institute (EBRI) to help with billing and enrollment of employers. EBRI is beginning to implement a plan for outreach that involves different media, including television, radio, and print media, focusing on small employers. Over the last year, DMA has simplified the process so that the form that must be used by employers for the IP is easier to complete. The previous form dissuaded some employers from participating; DMA realized that it was too complicated and made efforts to simplify it.

EBRI will also assist in enrolling beneficiaries into the IP; enrollees must complete the MBR in order to enroll. DMA has said they want to enroll 100,000 people into the IP, but respondents suggested it will take a concerted effort to meet this goal. Another concern is whether outreach for the IP enrollment is sufficient. As one respondent suggested, "we learned some things from our experience with outreach for the Senior Pharmacy Program (SPP). Can we apply these lessons to outreach for the IP?" For example, was it the best decision to do outreach for the SPP through a contractual arrangement? Or would it have been better for a state agency to do that outreach?

The Future of MassHealth

Several respondents suggested that the gains made by health reform have not really been "noticed." They wonder if people appreciate how much has been accomplished by health reform; "Health reform has been an incredible thing."

Most respondents indicated that they believe there has been little interest at the state level in projecting the future of MassHealth beyond the end of the waiver. The potential loss of the waiver could have enormous impact, since it will also involve the loss of federal funds directed to the state. Respondents suggested they would like to see Massachusetts be more creative in its use of the waiver to cover adults without insurance: "Perhaps we should develop a state only program like CMSP for adults." Interviewees suggested that typically Massachusetts implements incremental reform, but current policymakers do not seem to be thinking creatively about the next steps.

Respondents suggested that the most important thing to remember about the last two years is that we really have a "zero sum game." All of the programs are intertwined and MassHealth and Pool use are going to co-vary. A separate report in this series addresses the impact of health care reform on the Uncompensated Care Pool.

Respondents raised the issue of how long expanded eligibility guidelines can be sustained. As some respondents said "we have made commitments to serve people, and it is important to make sure we don't turn our back on people because we have not thought through all the fiscal implications of expanded MassHealth enrollment." One respondent also wondered what will happen to the people who are now eligible for MassHealth under the expanded eligibility guidelines, after they turn 65. Although they become eligible for Medicare benefits, these individuals lose their Medicaid eligibility because the expanded eligibility income rules do not apply to the population of people who are over 65.

Some respondents replied that there are still some people who fall through the cracks – primarily people who do not fit into MassHealth's eligibility categories, although it is not clear how large this population is. These are individuals who do not meet the categorical requirements for MassHealth, especially men who are seasonally employed, or undocumented immigrants. Many of these people are adults without children and most have incomes that are below 200% of the FPL. Some of these people share characteristics with the Basic population, but they are not long-term unemployed. In addition, there are people who are underinsured who still need additional coverage. DMA is studying this issue.

Going forward, a key policy issue will be the implementation of the IP. Respondents reported that DMA intends to fully implement this policy, but it is not clear whether these efforts will be successful. In addition, as a result of the huge increase in MassHealth enrollment providers are becoming more dependent on Medicaid reimbursement. This fact, combined with the impact of the BBA and HMO reimbursement rates means that providers are in a precarious financial position.

VI. Summary Program Impact

Is Health Reform Successful?

Looking at the impact of health reform on health care coverage for the state population, there are national survey data with historical information showing that Massachusetts is making real progress addressing uninsured rates compared to the national trend. According to data from the U.S. Census Bureau's Current Population Survey (CPS), the Massachusetts uninsured rates for all ages has dropped from 12.6% in 1997 to 10.3% in 1998, an 18% improvement. In comparison, the United States uninsured rate increased during this same time period from 16.1% to 16.3%. In the New England states, only Rhode Island and Vermont have lower uninsured rates than Massachusetts, although it is interesting to note that Vermont has actually experienced an increase in the uninsured rate between 1997 and 1998 while Rhode Island has remained fairly consistent around 10%. (see figure 23)

The Massachusetts Medicaid rate of insurance coverage has increased from 11.2% in 1996 to 13.7% in 1998, at the same time the uninsured rate decreased from 14.1% to 11.6% for ages zero to sixty four. In stark contrast are the U.S. figures for the same age group and time periods with national Medicaid rates dropping from 12% to 10.4% and uninsured rates climbing from 17.6% to 18.4%. (see Figure 24)

Examining the trends for the 0 – 64 age group, the national uninsured rate shows a steady and gradual increase between 1987 and 1998. Figure 25 shows the Massachusetts uninsured rate clearly declining between 1997 and 1998. In Figure 26 health insurance coverage provided by the private or government sector shows a steady and gradual decrease nationally, down to 81.6% in 1998. Connecticut and Massachusetts both show similar type declines between 1995 and 1997, and then the Massachusetts rate increases from 85.7% to 88.4% in 1998. Employment based health coverage in Figure 27 nationally exhibits a slow but steady increase since 1994 to 65.8% in 1998, whereas the Massachusetts and Connecticut

Figure 23 This figure shows 3 year trends in uninsurance rates for New England states and the nation for all ages.

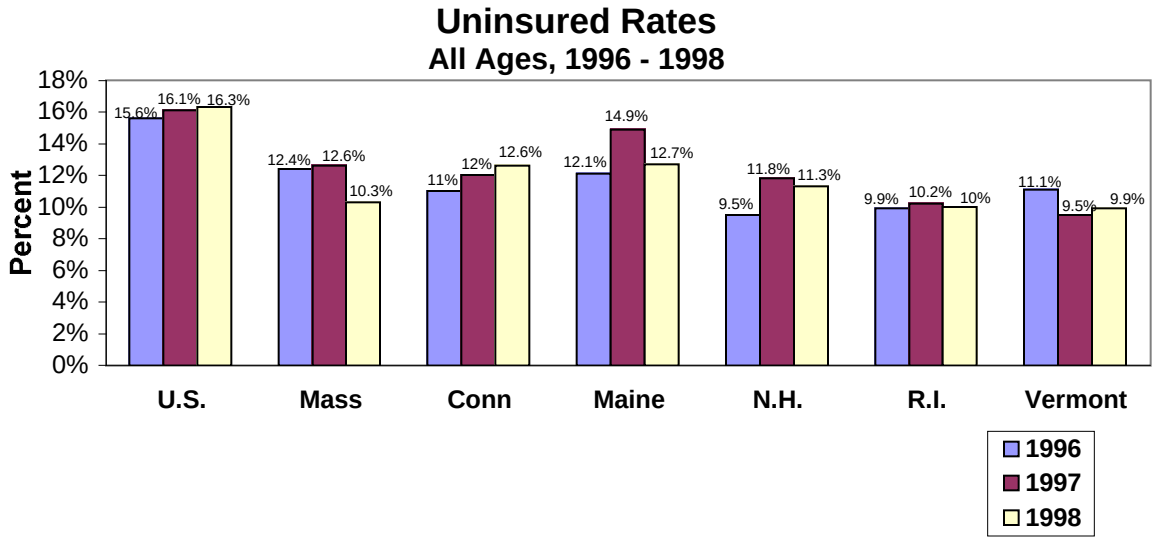
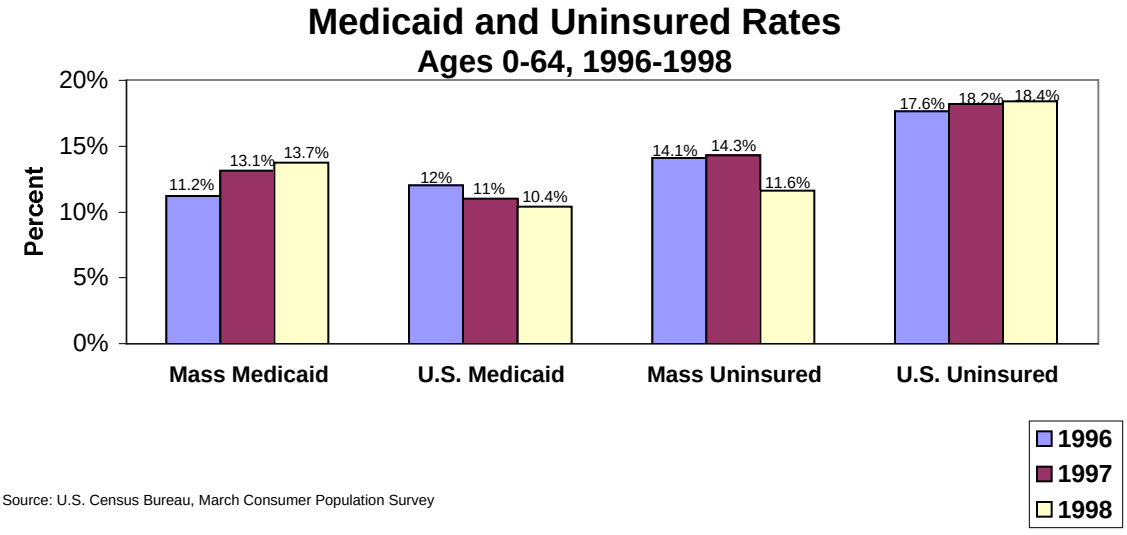


Figure 24 This figure shows 3 year trends in Medicaid and uninsurance rates for Massachusetts and the United States for ages 0 through 64.



Source: U.S. Census Bureau, March Consumer Population Survey

Figure 25 This figure shows trends in uninsurance for ages under 65.

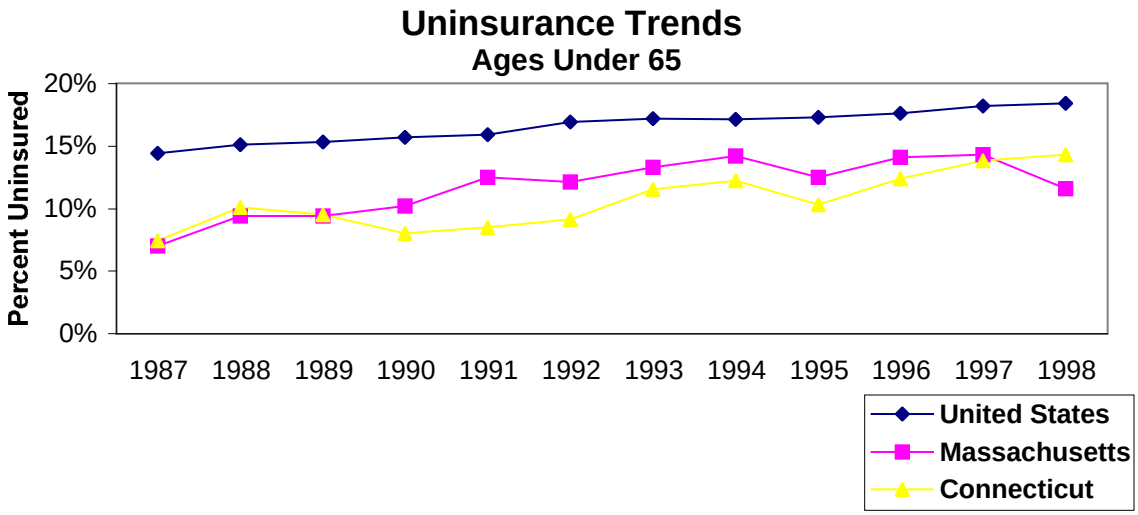
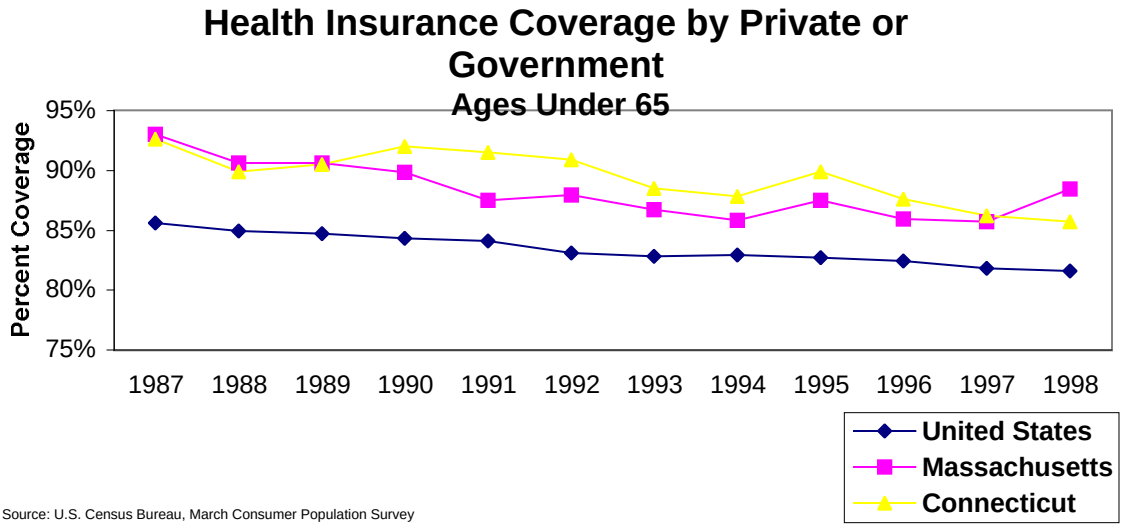


Figure 26 This figure shows the trends in private or government sources for health insurance coverage for ages under 65.



Source: U.S. Census Bureau, March Consumer Population Survey

Figure 27 This figure shows the trends in employment based health insurance coverage for ages under 65.

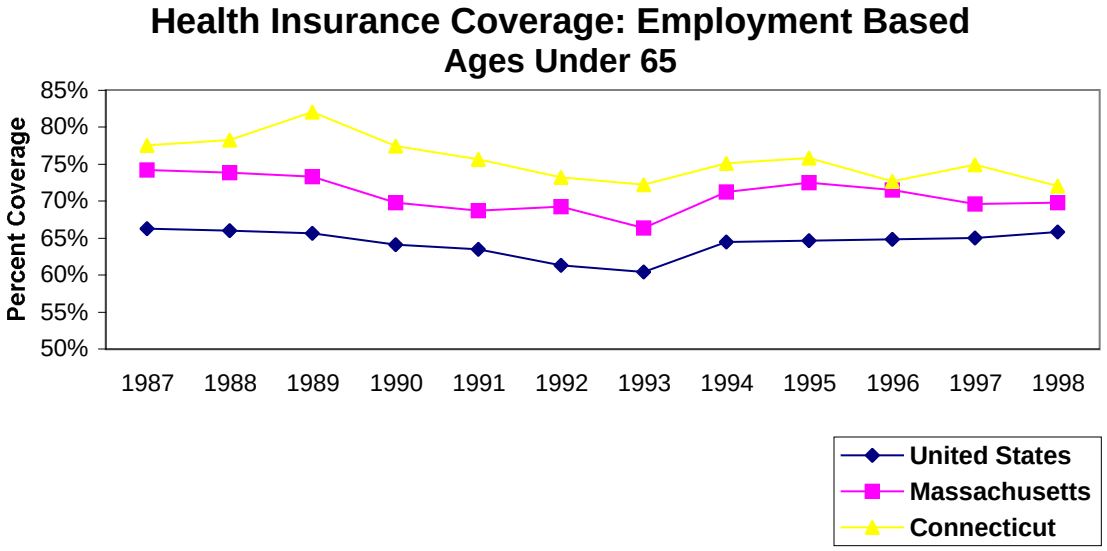
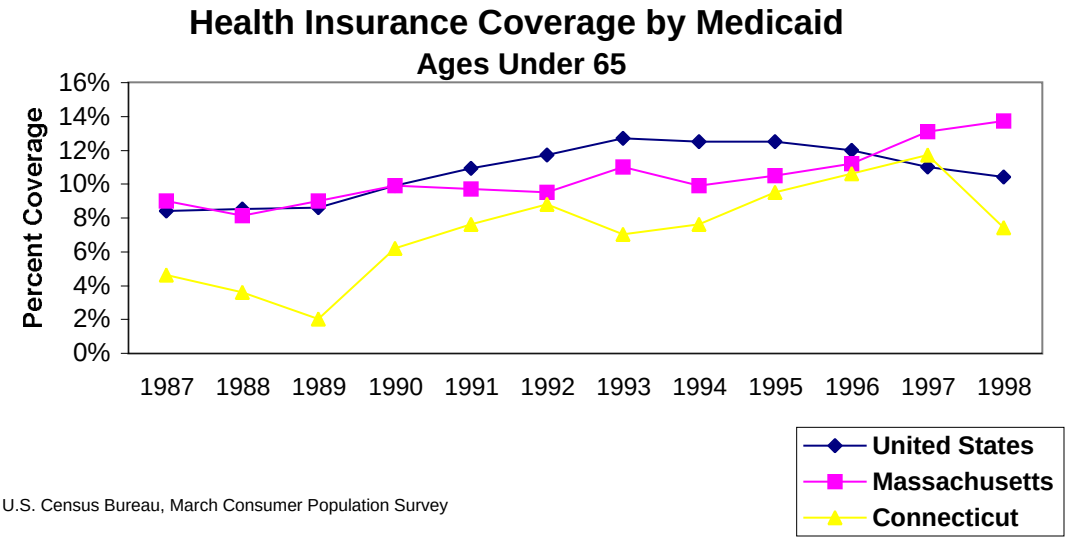


Figure 28 This figure shows the trends in Medicaid health insurance coverage for ages under 65.



Source: U.S. Census Bureau, March Consumer Population Survey

rates have varied more over that same time period. Both states exhibit higher rates of employment based coverage than the nation at 69.8% and 72% respectively in 1998.

The primary reason for the improvement in Massachusetts' uninsured rate is due to improvements in coverage by Medicaid. Figure 28 shows a steady increase in Massachusetts Medicaid coverage beginning in 1994, with a steeper increase occurring between 1996 and 1998 – a period reflecting the onset of the Massachusetts health reform expansions. The Massachusetts' health insurance coverage rate by Medicaid of 13.7% in 1998 is 31.7% higher than the national rate of 10.4%.

The data and interviews from key stakeholders provide clear evidence that from an enrollment perspective, MassHealth has been very successful. Enrollment of the health reform population increased nearly 28% in the first year of the expansion efforts, and as of June 30, 2000 there has been more than a 41% increase in the MassHealth health reform population since the beginning of the health reform expansions.

Impact on Other State Programs

The MassHealth expansions have had an impact on other state programs. Two programs operated by the Massachusetts Department of Public Health (DPH), Centercare and the Children's Medical Security Plan (CMSP) have experienced some major changes. The application for CMSP is now part of the MassHealth application process so that screening for the MassHealth program takes place first. Children are then referred to CMSP if they are not eligible for MassHealth. MassHealth has the advantage of offering a much broader benefit package, including acute hospital stays whereas CMSP covers only primary and preventive care services. CMSP program volume was directly affected as children were enrolled in MassHealth, and the population now served by CMSP has changed. Centercare is a program offering primary and preventive services through certain community health centers for adults. Due to volume declines, DPH has been funding fewer open Centercare spots at CHCs. These volume declines are also linked with the MassHealth expansions. There was an expectation that Uncompensated Care Pool use would also decline. In fact, there were declines in Pool usage, but given the financial environment that hospitals and CHCs are finding themselves in, there is also a concerted effort on the part of providers to maximize reimbursement wherever possible. In spite of providers push to maximize reimbursement, there is a clear decline in demand for the Uncompensated Care Pool.

Some Outstanding Issues and Questions

Overall, most observers agree that health reform has been a success from the perspective of increased enrollment in MassHealth. However, as described previously, there are still some outstanding issues and questions that were raised in this evaluation, in the areas of MassHealth eligibility and enrollment; financing for services; and access to care.

Issues related to eligibility and enrollment raised through this analysis include:

- Barriers to enrollment such as who is not being reached or responding to the outreach and enrollment activities, especially since the eligible population now left is harder to reach;
- the impact, both from a member health perspective and a programmatic perspective of churning – constant fluctuation in the population of individuals eligible for MassHealth benefits;
- coordination among various state agencies responsible for providing public benefits to the target population; and

Issues related to financing of MassHealth benefits, include:

- there are some concerns around DMA's ability to meet the state budget neutrality requirements for the program, particularly during the last year of the demonstration project,
- nearly every provider serving the MassHealth population is undergoing some kind of financial stress and major pressure for increased reimbursements is expected to continue,
- concerns exist regarding the post-waiver years, the level of state support in light of future projected budget shortfalls, and the potential loss of progress made during health reform.

Issues related to access include:

- How much MCO choice is really available in the Massachusetts market where many providers contract with the same one or two managed care organizations, coupled with market consolidation and HMOs no longer contracting with Medicaid?
- Choice of providers can be even more of an issue in specific geographic locations, for example in the western part of the state.

VII. Next Steps/Recommendations

The advances in health care coverage accomplished through MassHealth's waiver programs have been impressive and well received by key stakeholders across Massachusetts. In addition, several of the concerns raised during the previous evaluation of MassHealth have been addressed, such as revising the MBR to make it shorter and easier to complete, improving outreach to eligible populations, and improving enrollment and access to covered services for the MassHealth Basic population.

Recommendations for next steps thus focus on how to build upon the gains made over the last two years. The analysis presented here suggests that future efforts should focus on three main issues:

- Stability in the eligible population;
- Provider reimbursement; and
- The future of health reform

As described above, there appears to be considerable churning in the population of individuals eligible for MassHealth as individuals cycle through various states of insurance coverage. Fluctuation in eligibility has also resulted from the eligibility redeterminations which DMA is required to complete. Additional information about long term eligibility should become available over the coming year as the Division of Health Care Finance and Policy collects individual level information on Uncompensated Care Pool recipients, DTA develops a data linkage system with DMA, and CMSP continues its data connections with MassHealth. It will therefore be possible to link the different state data bases and match individual histories. With such longitudinal data it may be possible to develop eligibility strategies to address the churning issue.

Reimbursement rates continue to be a source of discontent among the MassHealth providers. Providers feel at risk in the current health care market, due to constraints on reimbursement rates from all major payers. Individuals interviewed for this report suggested that the overall financial health of providers is not solely an issue for Medicaid policymakers, but is relevant in understanding the impact of health reform.

Finally, stakeholders wonder what policy initiatives will follow health reform. Given the success of the demonstration, it seems natural for individuals involved in the system to look to the future with concerns about how the gains made under health reform can be sustained. As described earlier in this report, much has been accomplished through health reform, and all those contacted for in the process of completing this evaluation are unanimous in their desire to see these gains sustained over the long term.

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[i] A qualified employer must meet the following criteria: no more than 50 full-time employees, the health insurance available meets the DMA basic benefit level, the employer contributes at least 50% of premium, and the employer participates in the Insurance Partnership.

[ii] See "An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents, Chapter 3: The Uncompensated Care Pool," Massachusetts Division of Health Care Finance and Policy, August 2000.

[iii] See "An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents, Chapter 1: The Children's Medical Security Plan," Massachusetts Division of Health Care Finance and Policy, June 2000.

[iv] More current data on the Insurance Partnership is now available from DMA.

[v] All expenditure data is based on date of service expenditures.

[vi] See the Massachusetts Division of Health Care Finance and Policy "Preventable Hospitalization in Massachusetts, Update for Fiscal Years 1995 and 1996," April 1998 for further information on PHs.

Appendices

Appendix I: List of Interviewees

Appendix II: HEDIS results, Table A. Executive Summary of Performance

Appendix III: MassHealth Maps by Zip Codes
- Map 1: Number of MassHealth Members by Zip Code
- Map 2: Percentage of MassHealth Members by Zip Code

Appendix II

TABLE A. EXECUTIVE SUMMARY OF PERFORMANCE

Measure	MassHealth Mean	MassHealth Median φ	HEDIS Massachusetts ·	HEDIS National ·
1. Children's Access to Primary Care Providers				
a. 12-24 months	93.6%	91.4%	94.7%	91.7%
b. 25 Months - 6 Years	88.5%	85.0%	90.0%	82.1%
c. 7-11 Years	89.5%	93.1%	92.5%	82.9%
2. Well-Child Care				
a. 15 Months	58.1%	52.9%	74.5%	55.1%
b. 3-6 Years	73.1%	72.7%	78.5%	54.6%
c. 8-9 Years	78.1%	70.4%	not available	not available
d. 10-11 Years	51.0%	56.0%	not available	not available
3. Adolescent Well-Care	45.4%	43.8%	47.2%	30.0%
4. Follow-Up After Hospitalizations for Mental Illness				
a. within 30 days	68.6%	72.7%	65.8%	70.6%
b. within 7 days	47.5%	56.3%	not available	44.6%
5. Mental Health Utilization				
a. Inpatient Discharges per 1000 member months	1.7	1.1	2.8	2.2
b. Average Length of Stay	10.5 days	9.4 days	6.9 days	7.5 days
c. Percentage of Members Receiving Any Services	20.3%	14.2%	7.5%	5.6%
6. Chemical Dependency Utilization				
a. Inpatient Discharges per 1000 member months	2.1/1000	0.7/1000	1.7/1000	1.1/1000
b. Average Length of Stay	3.9 days	4.5 days	3.9 days	5.5 days
c. Percentage of Members Receiving Any Services	3.8%	2.0%	6.5%	4.0%

The MassHealth Mean is the Average of the plans, weighted to reflect the membership in each plan. This number represents the value for the average MassHealth enrollee. See page 7 for full definition.

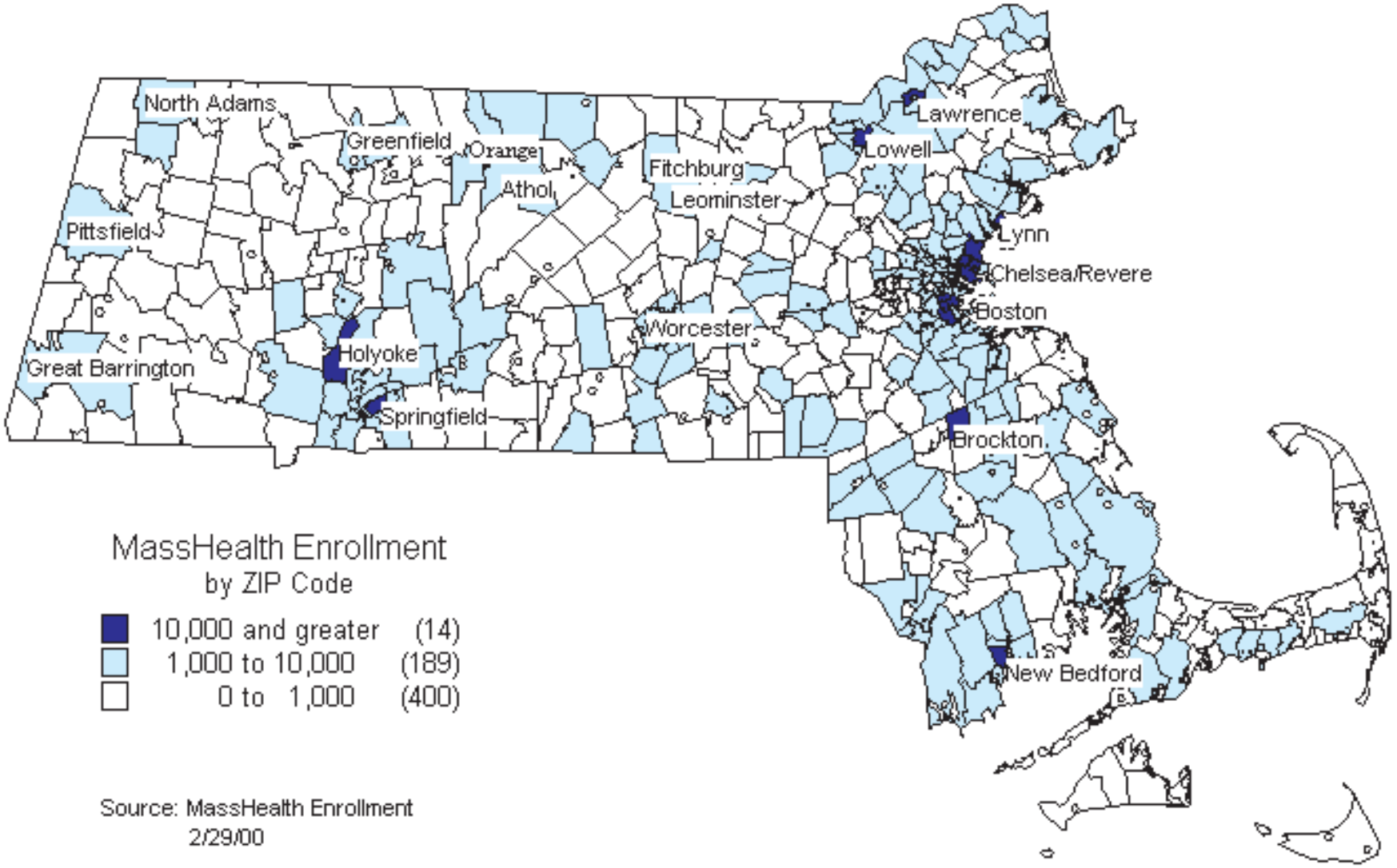
φ The MassHealth Median is the value of the managed car plan that is in the middle of the range of plans when ordered lowest to highest in terms of performance on the measure. See page 7 for a complete definition. The median is the rate that an enrollee would face in the "typical" managed care plan.

· HEDIS Massachusetts is the mean of all commercial Massachusetts health plans (n=15) included in the Quality Compass.

HEDIS National is the mean of all commercial health plans (n=277) in the Quality Compass.

Source: HEDIS Report 1999

Appendix III: Map 1
Number of MassHealth Members by ZIP Code



Appendix III: Map 2
Percentage of MassHealth Members by ZIP Code